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Florida State Interagency Committee on Mental Retardation Planning, Tallahassee.

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Information is provided on Florida's mental retardation facilities and programs, and specific recommendations and guidelines are given for the expansion and improvement of services. The following are specified: basic principles for the care of the mentally retarded; recommendations for legislative action, training centers, research, community action, and other public and private agencies and institutions; the development of state residential institutions; the nature of mental retardation, its causes, characteristics, degrees, and prevalence; and prevention, case finding, diagnosis, evaluation, and treatment. Also detailed are community and residential services; an enriched program of special education for the retarded, including training, rehabilitation, and employment; recommendations for research centers; a new legal concept of the retarded and dissemination of information to opinion-making groups; coordination of services on federal, state, and local levels; and commitments to needed areas of action. In all, 131 recommendations are made. Seven appendixes and a 39-item bibliography are provided. (BA)

The Florida Plan
for Comprehensive Action
to combat Mental Retardation

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The Florida Plan
for Comprehensive Action
to combat Mental Retardation

1965

EC002 741

Report to the Governor

State of Florida
Interagency Committee on Mental Retardation Planning
Tallahassee

This study was supported in part by a Mental Retardation Planning Grant awarded by the Public Health Service, U. S. Department of Health, Education and Welfare, Washington, D. C.

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STATE OFFICE BUILDING
725 SOUTH BRONOUGH STREET
PHONE 224-9149

June 30, 1965

Honorable Haydon Burns
Governor of Florida
The Capitol
Tallahassee, Florida

Dear Governor Burns:

It is with great pride that we transmit a copy of the Florida Plan for Comprehensive Action to Combat Mental Retardation.

A study was made pursuant to recently enacted federal legislation making funds available to the states to plan for the complex array of services that need to be established or extended for the mentally retarded.

This plan of action is the result of eight months of study and investigation conducted by the specially created Interagency Committee on Mental Retardation Planning and the Advisory Committee on Mental Retardation Planning. It reflects many ideas and suggestions of professional people and lay citizens. The study has endeavored to ascertain what comprehensive state and community action is needed -- to combat mental retardation in Florida and use the resources available for this purpose -- to develop public awareness of the mental retardation problems and -- to coordinate state and local activities relating to the various aspects of mental retardation.

The Plan envisions a bold step forward mainly in the direction of improving and broadening community-based programs for assisting the retarded citizen in reaching his fullest potential so that he may become a self-supporting member of society.

It is hoped that this Plan will accomplish the intended result and also help launch a vigorous effort for any necessary legislation in 1967.

Sincerely,

Gerald Mager
Gerald Mager
Chairman

James G. Foshee
James G. Foshee, Chairman
State Advisory Committee
on Mental Retardation Planning

GM/fcp

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FOREWORD

This report is the result of eight months of study made possible through the combined efforts of the State of Florida and a Mental Retardation Grant awarded by the Public Health Service, United States Department of Health, Education and Welfare.

The Plan represents both a culmination and a beginning — it represents the culmination of findings made by the President's Panel on Mental Retardation in 1962 which focused the attention of the nation on mentally retarded citizens — it also marks the beginning of Florida's most concerted effort in fulfilling its responsibility in helping those persons whose full growth potential has been impeded by physical and mental disabilities.

In retrospect, the past decade has been a period of historic significance in which great strides were taken to cope with problems of the mentally retarded in this country.

The late President John F. Kennedy dramatized the plight of the mentally retarded not only by creating a panel on mental retardation but, more important, by urging Congress to take legislative action. As a result of the late President's efforts, Congress enacted legislation to help the States initiate plans for comprehensive action to combat mental retardation.

With the adoption of PL 88-156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963," a total of $2.2 million was made available to the states for mental retardation planning.

As of June 30, 1964, Florida was awarded a grant of $30,000 to develop a state plan which would enable it to find out what resources the state had and what was needed to provide adequate services; also, to include proposed action to develop public awareness of the issues and to coordinate state and local activities.

The implementation of many of the programs and services recommended in this Plan will be possible with the subsequent approval by the

United States Department of Health, Education and Welfare of the State Construction Plan developed under the provisions of PL 88-164, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963." Formula grants will be available for the construction of day and residential, diagnostic, training and treatment service facilities for the mentally retarded.

Initial steps in the preparation of state planning for comprehensive action to combat mental retardation included the creation of a State Interagency Committee on Mental Retardation Planning and a State Advisory Committee on Mental Retardation Planning. In the formulation of this plan, a close liaison was maintained with the Legislative Interim Committee on Mental Health and Mental Retardation and with local mental retardation planning agencies to assure consideration and full recognition in the State Plan of the local mental retardation problems and needs. A list of the local communities whose plans of comprehensive services for the retarded were considered and, in fact, are a part of this Plan appears in the Appendices.

Though the Plan does not provide all the answers, the implementation of its recommendations through state and local action will be a substantial step forward in meeting the needs of Florida's mentally retarded citizens and their families.

Florida can take great pride in the progress that has already been made in behalf of mental retardation in the few short months during the preparation of this report. Through the efforts of the Office of the Governor, the Legislative Interim Committee on Mental Health and Mental Retardation and the voluntary and public mental retardation agencies, several significant laws have been enacted by the 1965 Legislature: a Division of Mental Retardation has been created to administer the State's mental retardation programs. As of July 1, 1965, this Division will become the State mental retardation authority and continue to administer the Sunland Training Centers. Where appropriate in this report, the new Division designation is used. Reference to "Sunland Training Center(s)" is made only with regard to specific programs of or for these institutions. Also of importance, was the enactment providing for the voluntary admission to the Sunland Training Centers. A summary of this act and additional legislation is included in Appendix B.

Though it would be impossible to express gratitude and appreciation through individual acknowledgment of all those who are concerned in the preparation of this report, an individual note of thanks must be rendered to the Staff of the Division of Mental Retardation and Dr.

James G. Foshee, Chairman of the State Advisory Committee on Mental Retardation Planning. To the many individuals composing the membership of the Interagency Committee on Mental Retardation Planning, the Advisory Committee on Mental Retardation Planning, the Legislative Interim Committee on Mental Health and Mental Retardation and the various Task Forces whose efforts are directly responsible for the preparation of this report, may I express on behalf of all the people of the State of Florida a debt of gratitude for your unselfish and tireless efforts. The full significance of these efforts will be revealed more poignantly in the months and years to come as the State Plan is being implemented.

We hope that this Plan will serve as a challenge to the many state, county and municipal officials and the public and private agencies, to continue to keep Florida moving forward in meeting the needs and problems of its mentally retarded citizens.

Gerald Mager, Chairman
Interagency Committee on
Mental Retardation Planning

June, 1965
Tallahassee
Florida

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The illustration and ideas were taken from the Mental Retardation Chart Book prepared by the President's Panel on Mental Retardation and released for the first time at the White House Conference (the Chart Book itself may be purchased from the U. S. Government Printing Office, Washington, D. C. 20402, at 45 cents per copy).

I

BASIC PRINCIPLES FOR THE CARE OF THE MENTALLY RETARDED

BASIC PRINCIPLES FOR THE CARE OF THE MENTALLY RETARDED

Concern for the mentally retarded is a measure of our adherence to one of the oldest and deepest tenets of civilization — a reverence for human life, human dignity and human potential. In keeping with this concept and in order to give full recognition to the problems created by mental retardation there are certain significant principles to which we must adhere:

1. Respect for the retarded as a human being first, and a handicapped individual secondarily. As a first class citizen he should have access to all general community services that he can use in common with others. Only when services fail to meet his needs should there be specialized care.

2. The retarded does not seek for nor does he need sympathy and pity; rather, he must have understanding and mature acceptance as a person with certain handicaps.

3. An opportunity for every child to achieve his maximum, well-rounded growth and development. The goals for the retarded are the same as for all children.

4. Full measure of justice for the retarded and their families under the law.

5. Obligations of society must be, where necessary, discharged by the State since mental retardation constitutes a medical, educational and social problem of vast dimensions.

6. Prevention of mental retardation. This takes the highest priority in any discussion of mental retardation. The primary physician who originally encounters the patient and his problem occupies a position uniquely favorable to effect preventive practices since he can note presumptive evidence of early retardation and can engage in appropriate planning with the patient and family.

7. Recognition of the pervasiveness of mental retardation and the need to develop a comprehensive program:

a. Separate services can no longer be planned, developed and administered in isolation. Plans for individual services must be developed from a comprehensive program.

b. Inter-related cooperation by all governmental parties is necessary. The problems of the mentally retarded are not and cannot be the sole responsibility of any one department of state government.

c. Planning of services and facilities for the mentally retarded should involve full participation of any governmental, voluntary, or other agency having a major responsibility to the mentally retarded, to the end that effective coordination be achieved. Any agency or group which is considered to have a significant potential for contributing some element to the overall program for the retarded should also be encouraged to participate in the planning process.

d. The concept of interagency, coordinated planning in mental retardation constitutes a major challenge to the field of public administration. It requires a high degree of communication and cooperation among relatively independent agencies, public and voluntary, and a real commitment to interdisciplinary framework.

e. Close cooperation should be maintained between State residential institutions and community services. This would permit the person able to leave group care to be received back into his community at the most favorable time. No retarded person should remain in an institution who can adjust outside. Moreover, services for the retarded should be close to their homes and families.

f. Close coordination of all medical resources, including but not limited to, diagnostic centers, the medical schools, State and private institutions caring for the retarded. This is essential for the development of research to determine the causes of mental retardation.

g. Planning of comprehensive services and facilities should be related to other forms of community planning and to social and economic trends.

8. Needs of the mentally retarded should be incorporated in the educational preparations of all professional people working with the retarded. Research and professional training are two essential components of the total program. A pattern of service is incomplete without them.

9. Adequate data should be developed to provide a base for developing services and facilities needed in the continuum of care and planning. This should be based on total and complete needs of the retarded rather than on the availability of financial support.

II

SUMMARY OF RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

This summary brings forth from the many proposals in the report, those recommendations meriting priority consideration by State and local agencies in combating mental retardation. The cross references are to additional supporting comments.

RECOMMENDATIONS FOR LEGISLATIVE ACTION

Definition — The following definition of mental retardation, proposed by the American Association on Mental Deficiency, should be proposed as law:

> **Subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.**

Diagnosis and Evaluation — Comprehensive diagnostic and evaluation service centers should be authorized for development in selected areas of population concentration. (p. 36)

Legislative Committee — A Legislative Interim Committee on Mental Retardation should be established at each biennial session of the legislature. (p. 92)

Admission and Discharge — A procedure should be established permitting voluntary admission of applicants to Sunland Training Centers without the necessity of a judicial determination. The Superintendents of the Centers, with the approval of the Division Director, should be authorized to discharge patients. (H. B. 395, 1965 State Legislature — Appendix B) (p. 75)

Pay Maintenance — Methods should be established for determining and collecting fees for residential care and services. An agency independent of the Division of Mental Retardation should determine and collect such fees. (p. 76)

Special Education — A plan for appropriate financing of school psychologists and psychometrists should be developed for inclusion into the Minimum Foundation Program. A close liaison and working relationship should be developed between the school evaluation personnel and community diagnostic and evaluation centers. The legislature should fully implement the Minimum Foundation Program by providing exceptional child instruction units to school systems as provided by Section 236.04(4), Florida Statutes, for the trainable and educable retarded children. Additional staff should be provided in the Exceptional Child Section of the State Department of Education. (pp. 59-60)

Coordination — A State Interagency Committee on Mental Retardation for the joint planning and coordination of comprehensive services for the mentally retarded should be legally established as a continuing body in the State of Florida. (p. 90)

Administration — Programs for the mentally retarded and the mental health programs should remain under separate administrative authority. (p. 93)

Public Awareness — A state-wide Citizens Council on Mental Retardation should be named, to encourage public support of State and community centered programs. (Implemented by House Bill No. 115, 1965 Legislature which establishes an Advisory Council to the Director, Division of Mental Retardation-Appendix B.) (pp. 84-85)

Every person in every agency which serves the retarded and their families in any way, directly or indirectly, should be encouraged to make public awareness about mental retardation a personal responsibility.

Other — If many of the recommendations which follow are to be implemented, legislative action (usually in the form of an appropriation of funds) will be necessary, often in combination with appropriate community action. Therefore, a "recommendation for legislative action" is implicit in many of the specific recommendations to follow.

RECOMMENDATIONS FOR DIVISION OF MENTAL RETARDATION ACTION

Sunland Hospitals — Additional units of Sunland Hospitals, not to exceed 500 beds, should be built near population centers as needed. (p. 48)

Sunland Training Centers — Additional Sunland Training Centers, not to exceed 250 beds, should be built in population centers, where appropriate community centers are lacking. (p. 49)

Research: Coordination — A Director of Research should function within the Division of Mental Retardation, to coordinate state and federal programs. A Research Council on Mental Retardation should be established to promote, evaluate, re-evaluate and coordinate research in mental retardation. This Council would be responsible to the State Interagency Committee on Mental Retardation. (pp. 70-71)

RECOMMENDATIONS FOR ACTION BY OTHER STATE AGENCIES

Welfare and Child Care — The State Department of Public Welfare should be appropriated additional funds for its Homemaker Service Program and its state-wide program of foster home care, to expand these services to mentally retarded children and their families. (p. 49)

Public Assistance Grants — Maximum grants to all public assistance recipients, including those who are mentally retarded, should be increased as should grants for nursing home care of retarded requiring this service. (p. 50)

Employment — Additional funds and staff should be allocated to the Employment Service so that sufficient selective placement interviewers may be provided for job development and placement of handicapped persons, including the mentally retarded. (p. 63)

Vocational Rehabilitation — The State Budget Commission should approve and the legislature should make available to the Division of Vocational Rehabilitation the funds necessary to fully match available federal funds to rehabilitate the handicapped. The Budget Commission and the legislature should approve the additional positions necessary to fully implement the program of the Division of Vocational Rehabilitation. Funds should be appropriated to activate Chapter 59-385, Laws of Florida, authorizing the Division of Vocational Rehabilitation to administer a program of self-care rehabilitation services for the severely handicapped. (pp. 61-62)

Training — Scholarship and leave programs, special institutes and workshops should be made available to appropriate personnel at suitable sites to increase the quantity and improve the quality of personnel involved in services for the mentally retarded. (p. 51)

Coordination — Within each state agency, which provides major services for the retarded, there should be at least one special consultant with sufficient agency-wide authority and responsibility for the development and coordination of services to the retarded. Funds should be appropriated for use by the State Interagency Committee on Mental Retardation to conduct pilot projects regarding the most efficient means of providing coordinated service for the mentally retarded at the community level. (pp. 91-92)

RECOMMENDATIONS FOR COMMUNITY ACTION

Prevention — Up-to-date prenatal, delivery and post partum care should be given to all mothers through the combined forces of physicians, hospitals and health departments. Any pregnant female must have hospital care available, based on need alone. Newborns must be evaluated, using the Apgar method or a similar method. Community and regional centers should educate the public generally, the mothers in particular, in the proper care of patients and newborns and should make counseling, casework and nutritional advisory services available. (p. 37)

Case Finding — Health workers and others who deal with the public as "helpers" should be trained to recognize signs and symptoms which might indicate intellectual handicaps in children. Schools will ordinarily discover the borderline mental retardation cases, but these "helpers" can find cases *earlier* so that effective action may be taken. (p. 39)

Treatment — All correctible physical defects should be discovered and a plan should be developed for their correction either by local action or through referral to the regional center. (p. 40)

Institutional Programs: Reduction — Community grants should be made to develop and maintain public or private sponsored non-profit comprehensive community programs. This will reduce the necessity for costly residential institutional programs. (p. 48)

Adult Training: Sheltered Workshops — A program of post-school services for the retarded should provide work evaluation, training, sheltered employment and activities programs for retarded children and adults needing these services. Where workshops are part of these services, or where these services are centered in workshops, there should be multiple disability workshops. (p. 62)

Camping and Recreational Programs — Every available means should be sought to provide camping experience for the retarded. Communities and existing residential camps should be encouraged to expand their camping programs in this regard. Recreation programs and other youth activities should be open to the retarded by program sponsors. (p. 51)

Coordination — Close liaison should be maintained by the State Interagency Committee on Mental Retardation with the local authority responsible for coordinating service for the retarded at the community level. (p. 93)

RECOMMENDATIONS FOR ACTION BY OTHER AGENCIES AND INSTITUTIONS

Training of Personnel — All regional centers should serve as training and observation centers for professional and technical personnel and as sites for refresher courses, workshops and similar training activities. Within the universities, each professional school should broaden courses in mental retardation in its curriculum. (p. 40)

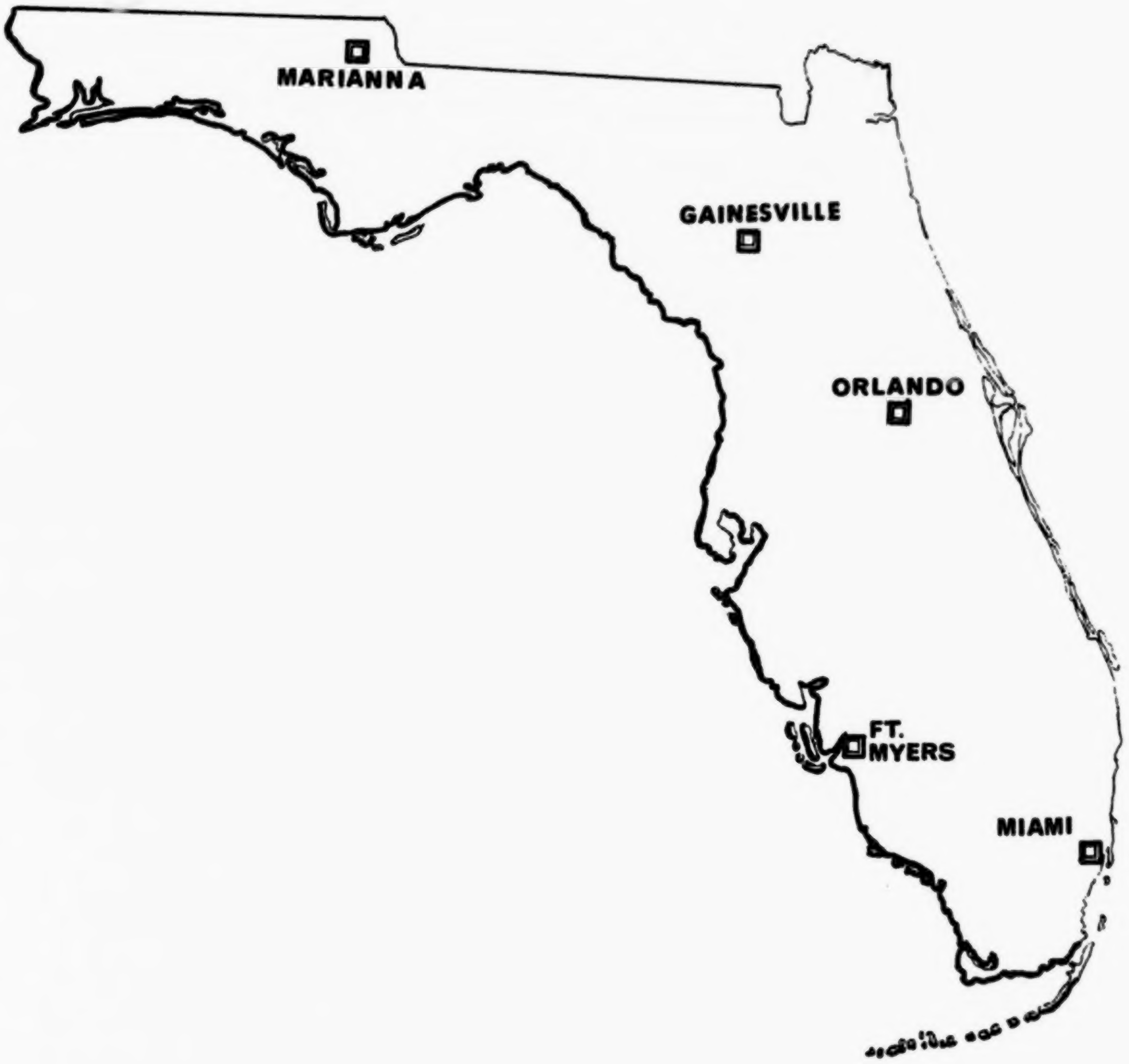
Mentally Retarded Offenders — The courts should take the lead in encouraging a broader view of the mentally retarded offender. In determining the responsibility of an offender, the courts should encourage a more liberal interpretation and should give proper consideration to the condition of the mentally retarded offender. (p. 80)

Research — Basic science research and research centers should be supported. University staff should be increased, to train researchers, and that staff should be given time to do research. Pilot projects in various research areas should be given state support. Federally-supported research facilities should be established at the Sunland Training Centers, independent of service facilities. (pp. 69—70)

Standards: Administration — There is considerable knowledge available in the field of community and residential service which is not being put to maximum use. Institutional and other administrators should make every effort to utilize this available knowledge, especially the wealth of standards which have come to be recognized and accepted in this field. (p. 52)

III

STATE RESIDENTIAL INSTITUTIONS


MARIANNA
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ORLANDO
FT. MYERS
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STATE RESIDENTIAL INSTITUTIONS
A HISTORY OF DEVELOPMENT

The Growth of Florida

As a result of being located in the southeastern corner of the United States, Florida was not in the path of the great westward migration that took place during the 1800's. Consequently, it found itself in 1900 with a population of little more than half a million people, sparsely settled over its 58,560 square miles of territory.

However, as the picture of a tropical paradise enticed people from every part of the United States to come to Florida, its population increased annually to the extent that by 1930 the population of the state had nearly tripled. Between 1950 and 1960, Florida's population increase of 79 per cent was the highest of all states. Its absolute gain over this ten-year period was exceeded only by California's. The annual increase was almost 6 per cent, compared to 2 per cent for the nation.

Florida, the third most rapidly growing state, now ranks ninth in population among the states, having moved from 27th in 1940 and 20th in 1950. Among the 12 southeastern states, Florida came from last place in 1940 to first in 1960. It is estimated that the population will exceed 7.8 million by 1975.

Mental Retardation Services: The Early Years

Fortunately, the people of Florida realized in the years prior to 1930 that some of their fellow citizens were not endowed with full mental capacity. The foresight of these people to visualize the needs of the "feeble minded," as the mentally retarded were once called, resulted in early planning of realistic programs which continue to benefit today's 174,000 mentally retarded children and adults living in Florida. Thanks to this foresight, and the great influx of people to Florida from throughout the nation, bringing with them knowledge and new ideas, the institutions and programs in Florida for the mentally retarded have not been strangled by outmoded concepts and traditions or administered by staffs resistant to change and new ideas.

In 1915 the Florida Legislature appointed a commission to investigate "the need of a state institution for the care of the indigent, epileptic and the feeble minded." This commission appeared before the legislature in 1917 and requested that they be allowed to continue their investigation for another two years in order to fully complete their study. In 1919 the commission reported an "alarming state of facts" and recommended a state institution for "these unfortunates." The legislature acted on this report by providing for the establishment of a state institution for the care of the epileptic and feeble minded.

And so it was that the Florida Farm Colony for the Epileptic and Feeble Minded was opened in 1921, under the management of a Board of Managers, on 3,000 acres of land donated by the citizens of Alachua County. This was Florida's first step in providing for the mentally retarded on the Cottage Plan and for the general purpose of care and protection. Additional buildings were added to the original three during 1923 and early in that year the Florida Farm Colony had a population of 242 persons.

In 1925 the Legislature enacted a measure transferring the control of the Florida Farm Colony from the Board of Managers to the Board of Commissioners of State Institutions. The construction of additional buildings from 1925 to 1927, increased the population of the Colony to 455 persons by 1930.

Florida Farm Colony: 1930 to the Present

Additional construction between 1935 and 1937 resulted in one new cottage, housing 38 people, and the original part of the first floor of the present hospital. Expansion of facilities has continued to take place, increasing the bed capacity to approximately 2,107, which is considered the maximum for this facility. Also, subsequent planning resulted in programs of education, training, and preparation for employment and return to the family.

Even though the first State institution for the mentally retarded began operation in 1921, there were no facilities for Negro children until 1953. On May 1, 1965, there were 897 Negro residents in the four Sunland Centers or 21 per cent of the total residents which numbered 4,304.

The 1955 Legislative Interim Committee on Mental Health traveled extensively throughout several states to study ways to provide adequate services for the mentally retarded in Florida. The members of the Committee and several interested Floridians visited the Institutions in Connecticut for a week.

Much credit is due the Florida Federation of Women's Clubs who in the early 1950's began a continuing drive to provide adequate State programs for the retarded. Through the efforts of these clubs, Florida began to move forward in developing plans for the future.

By act of the 1957 Legislature, the name of the Florida Farm Colony was changed to Sunland Training Center. It was felt that this new name was more appropriate to the emphasis of the program. The 1957 Legislature also placed the Sunland Training Center at Gainesville under the Division of Child Training Schools. This legislation provided for a Director of the Division who in turn was responsible to the Board of Commissioners of State Institutions.

The Connell Survey

In 1957 the Board of Commissioners of State Institutions commissioned the firm of Connell, Pierce, Garland and Friedman to study the problems of properly housing an adequate state program for retarded children in Florida. The findings and recommendations were published in a study entitled:

A Survey On Training Institutions for Retarded Children in Florida, which was revised in 1961 by the same firm.

Credit must be given to the survey for (1) its foresight as to the future problems, (2) its recognition of the role of community centers and (3) the need for residential institutions to use the cottage plan and to program beyond care and protection with education, training, preparation for employment and return to the family as part of the integrated services.

In addition to recommending 500 acre sites for state institutions within one hour's driving time of major trading areas, emphasis was placed on flexible cottage plans for effective classification of the residents, their training, recreation and daily activities. Additional recommendations recognized the need for community centers as a means of keeping waiting lists at a minimum and getting those in the institutions who could benefit from community services and programs back to their respective communities and families. Also of significance was the recommendation that good planning required state assistance to communities if these children were to be kept out of state institutions.

The Sunland Hospital at Orlando

The second facility for the mentally retarded in Florida was opened in Orlando in January, 1960. Known as the Sunland Hospital at Orlando, the facilities were formerly under the Florida Tuberculosis Board and consisted of a four-story building containing 500 hospital beds and other support buildings. In 1959, when the Florida Tuberculosis Board declared the hospital as surplus to their needs, the Board of Commissioners of State Institutions directed that the entire hospital complex be reoriented to serve the Florida program for the mentally retarded.

The facilities were ideally suited to those patients who were non-ambulatory, and profoundly and severely retarded. By May of 1961, 605 patients were living at the hospital, served by 576 full-time employees. The number of patients increased to 835 by July, 1964, with the capacity of 1,000 residents expected to be reached by the end of 1965.

The Sunland Training Center at Fort Myers

This Center opened in April of 1960, designed and constructed essentially along the lines recommended by the Connell survey. This completely new institution was designed as an across-the-board program for mentally retarded children. The basic design of the institution was for a maximum of 1,500 children, but construction was limited to housing for 1,008 persons. Like the Sunland Training Center at Gainesville, the Fort Myers complex was developed on the cottage plan of service.

The Sunland Training Center at Marianna

In 1961, the Connell survey was supplemented by a study titled *Sunland Training Centers for the Mentally Retarded in Florida,* conducted by the same firm. This report went much more deeply into the problem of the mentally retarded in Florida. It contained further recommendations as to the needs of the retarded, and the numbers and geographical locations of institutions which would best serve the state's retarded.

One of the recommendations pointed out the need for a facility in northwest Florida. After a survey by a site committee, the deactivated Graham Air Base near Marianna in Jackson County was selected and was open to admission of the mentally retarded in January of 1963. Since the Center was established on a deactivated air base, many buildings were already in existence that could be readily put to use. The former cadet barracks were remodeled on the cottage plan, and there were ample buildings for administration and staff housing. In addition, there were extensive recreational facilities available for immediate use. As of May 1, 1965, there were 500 residents living at the Marianna Center.

Recent Developments

On July 1, 1963, the Sunland Training Centers and the Sunland

Hospital were separated from the Division of Child Training Schools and placed under the Division of Sunland Training Centers with offices in Tallahassee. A Director was appointed to head the Division and by August 1, 1963, the Division was in full operation. Immediate action was taken by the Division to expedite plans for expanding the number of institutional facilities as authorized by the 1963 Legislature. Priority had to be given to new construction, since the waiting list of patients applying for admission to the existing Centers numbered well over 1,000, and new applications were being received at the rate of 80 a month.

The first phase of expansion authorized by the 1963 Legislature was the building of a Sunland Training Center in Dade County. The construction in Dade County is underway, and it is estimated that 380 beds will be available about December, 1965. Present planning calls for this facility to be increased to 1,000 beds by 1967. As another necessary step, it is hoped that the bed capacity of the other Centers will be expanded to permit the State's residential institutions to accommodate 6,100 persons by July, 1967, contingent on funds being made available.

Realizing that the state is unable to construct a 1,000-bed institution every year, the Division of Sunland Training Centers and the Board of Commissioners of State Institutions took an active part in developing other avenues to combat mental retardation in Florida. The Board acted quickly in December, 1963, to take advantage of recently passed federal legislation which provided grants to the states for initiating planning of comprehensive community services for the mentally retarded and for the planning of construction of mental retardation facilities in the communities. The Division of Sunland Training Centers was designated to administer these grants.

In June, 1964, Florida received a $30,000 grant to carry out the purposes of the federal legislation, and on July 1, 1964, a planning director was appointed to coordinate the preparation of a State Plan of Comprehensive Services for the Mentally Retarded.

As the result of a supplemental grant of $15,000, a public information officer was added to the staff March, 1965, to provide technical assistance to the local communities in developing programs of education and public awareness of mental retardation.

The most recent stage in Florida's history of accomplishment was the passage of an act by the 1965 Legislature which created a Division of Mental Retardation replacing the Division of Sunland Training Centers. The new law expands the responsibilities of the Division to include the planning, development and coordination of a complete and comprehensive state-wide program for the mentally retarded and designates the Division as the state mental retardation authority. This legislation takes effect on July 1, 1965.

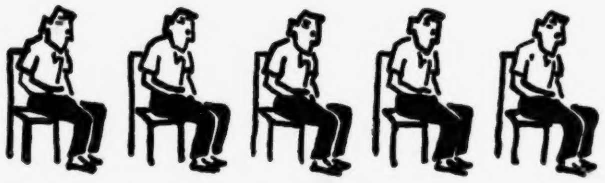
These things have been accomplished. The report that follows indicate what must yet be done.

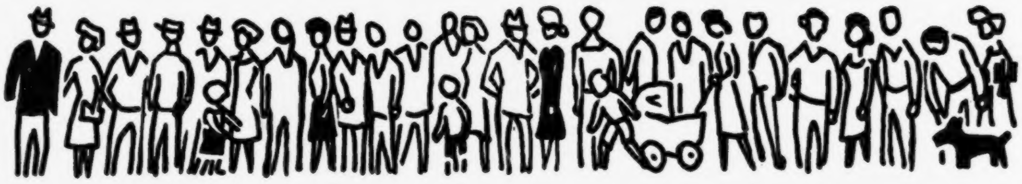
IV

THE NATURE OF MENTAL RETARDATION

MENTAL RETARDATION TOUCHES MANY PEOPLE

174,000 PEOPLE ARE MENTALLY RETARDED





THEY AND THEIR FAMILIES ADD UP TO ABOUT 600 THOUSAND PEOPLE
OR ABOUT 10% OF THE POPULATION

THE NATURE OF MENTAL RETARDATION

What is Mental Retardation?

Mental Retardation is not a disease, but a resultant condition. (1) It has different meanings in education, in medicine and in the contemporary job market, to name only three areas among many that are important.

The modern definition accepted by the American Association on Mental Deficiency describes mental retardation as significant "subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behaviors." (2) In less technical terms, the mentally retarded person is one who, from childhood, experiences unusual difficulty in learning and is relatively ineffective in applying whatever he has learned to the problems of ordinary living; he needs special education, training and guidance to make the most of his capacities, whatever they may be. A small percentage of retardates function so inadequately so as to require constant physical care; the majority, if given adequate educational training, may be able to live independently as adults. Mental development, like physical development, is promoted by the right kind of activity and stimulation, and retarded when it is lacking. Indeed, the two tend to interact. In this process, when the nervous system is maturing and language developing, the years of early childhood are certainly very critical.

What are the Causes?

Mental retardation can be caused by any condition that hinders or interferes with development before birth, during birth or in the early childhood years. Well over 100 causes have already been identified, although these account for only one-fourth of all identified cases of mental retardation. Retardation caused by biological factors brings permanent disability and, is therefore, not like mental illness. The mentally ill are persons with normal ability who have severe emotional disturbances. The symptoms and treatment of mental illness are quite different from those of mental retardation. Occasionally, a mentally retarded person becomes disturbed or mentally ill from the stresses of life, and then he needs a program for both conditions.(3) (Appendix-C)

From 10 to 20 percent of the total groups of mentally retarded are known to have some demonstrable pathology in the structure or function of the central nervous system. This pathology is presumed to be directly responsible for producing the mental retardation. There are literally scores of specific diseases and conditions which have been known to produce damage to the brain and result in retardation.

About 80 to 90 percent of all mental retardates do not show gross abnormality of the brain. A small number of this group appear retarded because of long-standing emotional or psychotic disorders of childhood which have interfered with learning. A few are retarded because of a secondary disability such as impaired vision or hearing or cerebral palsy which has resulted in a restriction of learning opportunities essential to normal intellectual development. The great proportion of this group, however, are persons who appear quite normal in the physical sense but who function as mentally retarded. These persons invariably derive from and have been reared in socially, economically and culturally disadvantaged environments. They are heavily represented in the slums of the metropolitan centers of the country and in depressed rural areas. Their greatest concentration is among minority groups residing in city slums. These conditions may not only mean absence of the physical necessities of life, but the lack of opportunity and of motivation.

These persons will most often have mild degrees of impairment in measured intelligence, that is between IQ 50 or 55 and the upper limit IQ 84. They usually are considered as educable children in school and generally fall into the mild and moderate degrees of impairment in adaptive behavior in adult life.(4)

To What Extent Do the Mentally Retarded Differ From Other People?

Before attempting any classification, society must remember that children and adults with disabilities are children or adults first; that is, a retarded child or adult is "a child or adult who is retarded."

The extent to which the retarded differ from the normal depends upon the degree of mental retardation. Those who are least retarded are difficult to distinguish from the "dull normal" members of the population. Those whose handicap is extreme may never be able to master such tasks as feeding and dressing themselves.

Because mental retardation is a relative concept depending on prevailing educational and cultural standards, there is no completely satisfactory measure for mental retardation. Complexities abound and eventually reliance for program planning must be placed in the hands of professional persons responsible for diagnosis, training, education, rehabilitation and employment.

The degrees of mental retardation are measured by considering both "measured intelligence" and impairment in "adaptive behavior." Since "measured intelligence" usually ties quite closely to academic learning ability, this factor assumes greatest importance in childhood, whereas "adaptive behavior" — the ability to make a living and to handle oneself and one's affairs with the procedures ordinarily expected of an adult in our society — is the more important determinant of the degrees of retardation in an adult.

The terms that are used in this report are described as follows:

The Educable Retarded (Upper Range)

Children who are classified as *mildly retarded* (IQ 55-70) are frequently called "educable mentally retarded" by educators. Though these individuals are unable to benefit adequately from regular school classes, the majority of them can become literate and economically and socially independent when added attention, especially trained teachers and a level and type of curriculum is adjusted to their ability and future needs. Approximately 85 percent of the retardates fall in the upper range. Persons whose measured intelligence is about an IQ 70-85 may be considered retarded if their adaptive behavior so indicates.

The Trainable Retarded (Middle Range)

The trainable retarded are usually classified as *moderately retarded* (IQ 40-54.) These individuals show a rate of mental development which is less than half of that normally expected and which precludes successful participation in programs of instruction for the educable retarded, i.e., the majority of these individuals cannot become literate. In classes of instruction geared to their level, however, they can learn verbal communication, motor skills, self-care, social adjustment and to perform many useful tasks in their home, neighborhood or in a sheltered working situation. Many *severely retarded* (IQ 25-39) individuals are properly classified as "trainable" for educational and habilitation purposes. Approximately 13 percent of the retardates fall in the middle range.

The Dependent Retarded (Lower Range)

This range includes the remainder of the retarded population (2 percent): the profoundly retarded (IQ 0-24) and many of the *severely retarded* individuals (IQ 25-39). The profoundly retarded are individuals who can respond to training in habit formation, but many cannot become independent even in eating and dressing. Their level of potential can best evolve by participation in community day-time activity centers or in programs of a residential care facility. The severely retarded can learn self-care, but their potential economic usefulness is extremely limited. However, many of the severely retarded, as most of the moderately retarded, can be properly classified as "trainable" for educational and habilitation purposes.

Prevalence

Though no precise statement of prevalence rates within each of these levels of retardation can be made, another widely used set of percentages based on intelligence test scores, and comprising a 3 percent total prevalence rate is as follows: *Educable Retarded 2.5%, Trainable Retarded 0.4% and Dependent Retarded 0.1%.(5)*

Two factors must be borne in mind in considering prevalence: (1) the percentages of identified mental retardates vary dramatically as a function of age, and (2) prevalence figures vary markedly as a function of the socio-economic level of a community or neighborhood.

In planning for a large number of retarded people, this grouping is helpful, yet authorities note that the term "mental retardation" may describe an individual at only one period of his life.(6) For example, a *mildly retarded* individual may move in and out of a segment of the population called retarded, as greater and less demands are put upon him by society. As a preschool youngster who stays at home, he is usually not distinguishable from normal individuals until school age when he becomes identified as retarded by an inability to learn general school subjects. However, given timely training, guidance and supervision early enough in life, he will be capable of complete assimilation in the adult society. Thus, the same individual with the same learning limitations presents a record of retardation during only one part of his life.

The fact that the manifestation of mental retardation varies significantly among different age groups and also among different types of retardation was recognized by the President's Panel in its acknowledgment that:

> "Only a small proportion of infants is identified as mentally retarded, because only gross defects are apparent and intellectual deficits which may show up later in life are not yet obvious. Many of the causative physical and environmental factors have not as yet had a chance to adversely affect the infant. By far the heaviest prevalence comes during the school age when more exacting requirements of behavior and intellectual performance are imposed. Some surveys of school population have shown that in the age group of 10 to 14, as high as 8 to 10 percent of the children appear to be mentally retarded. Then as these retarded individuals approach adulthood there is a tendency for many of them to be assimilated into the population and for the differences to disappear. This helps explain why studies have found varying rates of retardation, ranging to as low as 1 percent of the population. The age-group figures cited are only rough estimates because there are no authoritative survey statistics available."(7)

The Size of the Problem

In order to understand the full scope of the problems of mental retardation, it is necessary to present some basic statistics on its frequency and on the number and type of people involved.

Mental retardation ranks as a major national health, social and economic problem affecting our nation's youth without regard to race, color, creed or socio-economic level. The ratio of mental retardation to the total population persists. As a cause of lifetime disability and as a medical, social and educational problem of unique extent and complexity, mental retardation presents an outstanding challenge to the related sciences and society.

Such diseases as whooping cough, diphtheria and scarlet fever have been almost eliminated. Tuberculosis has been reduced 30 percent in five years. Polio has been dramatically reduced.

Mental retardation, as a disability, afflicts twice as many individuals as blindness, polio, cerebral palsy and rheumatic heart disease combined. It disables 10 times as many people as diabetes, 20 times as many as tuberculosis, 25 times as many as muscular dystrophy and 600 times as many as infantile paralysis.(8)

An estimated 75 percent of mentally retarded persons have one or more types of physical disability. The second disability may be minor in nature, but in many cases [illegible] is a severe handicap such as impaired hearing or vision, poor muscular coordination or some physical abnormality.(9)

Though there have been several prevalence studies, there is no available data which permits a precise statement of the prevalence of mental retardation. This is due to limitations in scope of studies made, to the use of diverse definitions of mental retardation, to the variability of measuring instruments used and other factors.

The estimates of mental retardation in the total population usually range from 1 to 3 percent depending upon the age groups studied. As related above, the reason for this spread is that the mentally retarded are more visible at different age levels and as more exacting requirements of behavior and intellectual performance are imposed by the environmental factors. In view of the difficulties faced in giving exact figures as the size of the problems, it would be safe to say that about 3 percent of the state's population could be classified as mentally retarded at one time or another in their life.

Using this generally accepted prevalence rate of 3 percent, Florida had approximately 172,000 mentally retarded children and adults as of July, 1964.* (10) This number would increase to about 210,000 by 1970. These estimates are valuable for providing a general or overall awareness of the extent of the problem of mental retardation in Florida.

There is a general concensus that the prevalence rate of the school age population is much higher than that found in either the pre-school or adult group. Results of available prevalence studies do show the same characteristics of lowest rate in pre-school years (about .05 percent) a sharp increase during the school years, (about 3 percent) and a decline in the post-school years to about 1 percent as the proportion of mentally retarded adults in the general population who are still identifiable and in need of special services.

For the purpose of specific program planning for specific groups, such as school-age trainable and educable and retarded young adults, it was deemed reasonable to use the different measurement standards as enumerated above in trying to estimate the number of individuals needing services today and by 1970.

The estimated prevalence of mental retardation in Florida for the estimated total population in 1964 and 1969 and the school-age population is summarized in Table A which provides an insight to the size of the problem.

The figures pertaining to the school-age population are particularly relevant for special empahsis in school program development. Though

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*Florida's population is up 3.1 percent from July 1, 1964 and now stands at about 5,796,000. Between 1950 and 1960, Florida's population increase of 79 percent was the highest of all states. Its absolute gain over this ten year period was exceeded only by California. The annual increase was almost 6 percent, compared to 2 percent for the nation.

Florida, the third most rapidly growing state, now ranks 9th in population among the states having moved from 20th in 1950. It is estimated that Florida's population will exceed 7 million by 1970. Approximately 8.4 million are expected to be residing in Florida by 1975.

Florida has made great strides in providing special education and training for the retarded, the 1963-64 report of the State Department of Education indicates that over 20,000 retarded children did not receive the education and training they needed for their development. A serious need for special programs such as guidance, counseling, sheltered workshops and vocational habilitation is evident in the fact that over 35,000 unserved young adults could have benefited from these services.

It is apparent that the problems of mental retardation are of major magnitude and that all services for the mentally retarded fall short of demand. No service for the mentally retarded has yet been inaugurated in any community and found itself with a shortage of clients once the availability of the program was known. The fact that the continued demand and need for service will be exceeding the availability of such services, is evident of the huge task ahead for the State and the communities of Florida. Comprehensive program planning, not in relation to some overall prevalence figure such as 3 percent but in relation to prevalences of the various levels and subcategories of the mentally retarded will have to be continuous to meet the demands and needs of the mentally retarded.

Table A

Estimated Prevalence of Mentally Retarded in Florida

Age	1964			Summary 1963-64 Services				1969		
				Number Retarded Served						
	Estimated Population (1)	Estimated Prevalence % (2)	Estimated Number of Retarded	Public Schools	Sunland Centers	Private Schools and Workshops (3)	Estimated Unserved	Estimated Population	Estimated Prevalence % (2)	Estimated Number of Retarded
0-5	840,000	0.5	4,200	XXX	250 (6)	315	3,628	1,010,000	0.5	5,050
6-18	1,265,000	3.0	37,950 (4)	13,572 (5)	3,129 (6)	1,176	20,301	1,516,000	3.0	45,480
19-44	1,830,000	2.0	36,660	XXX	602 (6)	437	35,776	2,210,000	2.0	44,200
45-over	1,770,000	1.0	17,770	XXX	130	XXX	17,640	2,150,000	1.0	21,500
TOTAL	5,705,000	1.69	96,580	13,572 (5)	4,111	1,930	77,345	6,886,000	1.68	116,230

(1) Based on suggested projections by Florida Development Commission.

(2) Estimated on the basis of information from various sources listed under "References To Notes."

(3) Based on 1965 survey of known programs sponsored by local Associations for Retarded Children and other private, non-profit organizations.

(4) Educable (2.5%) — 31,625
Trainable (0.4%) — 5,060
Profound (0.1%) — 1,265

(5) Served by Public Schools

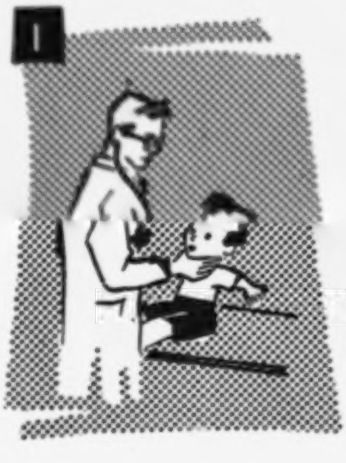
Educable	12,277
Trainable	1,295
Total	13,572

(6) Age grouping in Division Reports varies slightly from age grouping used in Table.

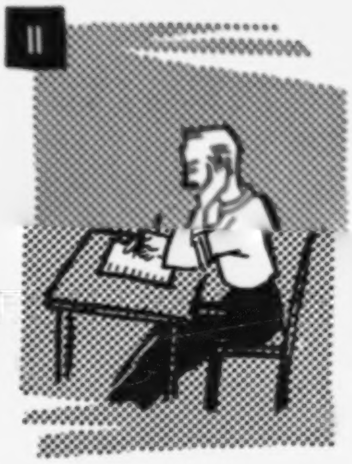
V

PREVENTION, CLINICAL DIAGNOSIS, EVALUATION AND TREATMENT

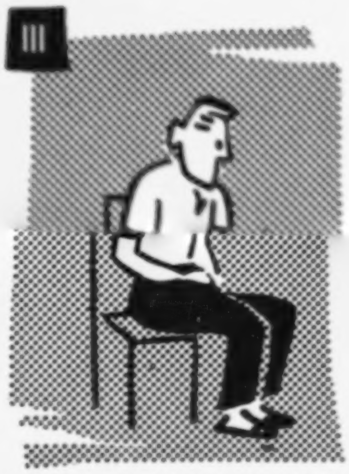
THREE MAJOR MEANS BY WHICH THE MENTALLY RETARDED CAN BE IDENTIFIED



MEDICAL DIAGNOSIS
MOSTLY OF THE SERIOUSLY
RETARDED AT PRE-SCHOOL AGE



**SCHOOL TESTS AND
UNDER ACHIEVEMENT**



**RECOGNITION OF
SOCIAL INADEQUACY**

PREVENTION, CLINICAL DIAGNOSIS, EVALUATION AND TREATMENT

Introduction

Regarding the areas of prevention, clinical diagnosis, evaluation and treatment, it seems clear that Florida cannot afford the luxury of separate facilities for cerebral palsy, epilepsy, orthopedic deformities, mental retardation and the many other handicapping conditions evident in our society. The majority of mental retardates also exhibit other handicaps; multiple handicaps are common in individuals who present what appears to be a single handicap, and many physically handicapped children have some degree of mental retardation. Therefore, the multidiscipline clinic capable of the diagnosis and evaluation of a broad variety of handicaps is really what is being advocated in this chapter, even though the discussion will be in terms of mental retardation.

The multidisciplinary clinic team must be under the direction of a competent, well-trained physician. The philosophy of the team should be to determine all the problems, major and minor, of the individual under study. This total evaluation must include all the tests and procedures which will contribute to a thorough understanding of the disability.

Retarded children have the same needs that normal children have, but in addition they each have a disability requiring certain appropriate, special attention. Furthermore, there is no substitute for family life, particularly for young children. Therefore, every effort should be expended to keep the retarded infant and pre-school child with his family. Within this family setting, proper professional guidance can most effectively channel the retardate's development and social adjustment.

To accomplish these ends there must be sufficient community resources close at hand. Florida is not without resources — both community and institutional — and as proper funding and adequate planning make themselves felt, we can anticipate major progress toward providing what is needed over the next three to five years. Though progress is expensive, time consuming and often difficult to achieve, the handicapped need and deserve the funds, time and effort that will be necessary. Society has too long neglected the handicapped. They look to the community leadership in health, education and welfare — in cooperation with the state's executive and legislative bodies — to fulfill their needs and permit them to assume a productive place in society.

Current Resources

There are sixty-seven county health departments in Florida, a number of which will have no health officer at any given time. One county has no physician, five have no dentist, eight have no hospital, and thirty-eight counties — over half of the state's counties — have no pediatrician. There is at least one public health nurse active in every county, and in addition, 20,946 practicing nurses are active in the state.

The Florida Crippled Children's Commission provides services to the entire state through ten district offices. The county health departments provide basic service to mothers and children through health department clinics in most of the counties. A state registry of Phenylketonuria (PKU) cases is maintained by the Florida State Board of Health, and a program of PKU detection has been established in county health departments. Dietary supplement, nutritional advice, home training and home visiting are provided by local or state personnel or both to those families seeking such assistance. Twenty-six mental health workers serve in various locations throughout the state, and social workers, while in short supply, are available in major population centers.

The single well-organized clinic for comprehensive diagnosis and evaluation of the mentally retarded is The Developmental Evaluation Clinic, a joint public health-medical program located in Miami. Since the clinic is committed to teaching, research and community activities, its service output is restricted. A new clinic styled along the same lines is under development at Tampa, and some basic plans have been discussed for similar facilities at St. Petersburg and Jacksonville.

The two medical teaching and research centers of Florida have numerous facilities, resources and services at their command, but their services are not usually available to the majority of the state's population, primarily because of the distances involved.

The three Sunland Training Centers and the Sunland Hospital in Orlando provide residential care, medical service, education and training and a sound research program for the patients and problems of mental retardation. A new residential center is now being constructed in Dade

County, which is said to be the last "big institution" that will be built in Florida. Indications are that this center will have a diagnostic outpatient clinic as part of the total facility.

Needs

Prevention

Obviously, our most important long-term goal is to prevent the future occurrence of mental retardation. Unfortunately, so little is known at present about the origins and causes of these cases that prevention is more often a hope than an actuality. However, it is certain that there will be new knowledge forthcoming which will be useful in prevention during the coming years. In addition, there are certain known causes which can be controlled, or their effect on the developing fetus can be lessened. Every person involved in serving mothers and newborns must extend every effort to assure the maximum possible control of these causes.

A percentage of mental retardation is known to be concerned with defective genetic mechanisms, but not nearly enough is yet known of this science to prevent a significant number of cases. Therefore, genetic research must be supported, and genetic counseling must be made available whenever appropriate.

A significant number of cases of mental retardation occur as a result of certain infections, accidents, certain poisons, certain drugs, child abuse, exposure to excessive radiation and similar external forces acting on the mother and fetus or the infant after delivery. Most of these cases of mental retardation can be reduced by appropriate preventive practices and specific protection of the mother and newborn.

Finally, the vital part played by adequate medical care and diet during pregnancy, at the time of delivery, and immediately thereafter cannot be overstressed. Public health personnel, private medical practitioners, hospital administrators, public welfare representatives and the public at large must concern themselves with these problems, not only for humanitarian reasons but also because of the heavy financial burden each community shoulders every time a mentally handicapped child is delivered.

Case Finding

The first step to appropriate care of the mentally retarded is to locate each case and bring it to an adequate diagnosis. Too often cases are relegated to institutions or are hidden by families who fear social stigma. Such cases must be found and brought to diagnosis so that a program of education, care and training may be developed which can assist them toward a fuller life with a possibility of productive participation in society. The medical and dental professions, organized nursing, the school, the church, welfare agencies, nursery and day training operators and others must be made aware of this problem, must be increasingly alert to find these cases, and must be prepared to discuss the proper evaluation of apparently abnormal children with the families involved.

Diagnosis and Evaluation

If prevention and case finding activities are to be meaningful, quality diagnostic and evaluative facilities must be readily available for every person needing these services in the state. A number of diagnostic and evaluation centers are needed in areas of major population concentration. These centers need to be staffed with a basic clinic team and with consultants as needed. A recommended basic clinic team and necessary consultants includes the following:

Basic Clinic Team

Physician Director (Pediatrician or Pediatric Neurologist)
Clinical Psychologist
Clinical Social Worker
Public Health Nurse
Clerical Aides

Consultants Required

Neurologist, Psychiatrist, Orthopedic Specialist, Ophthalmologist, Radiologist, Geneticist, Obstetrician
Educator, Nutritionist, Audiologist, Rehabilitation Specialist
Speech Therapist, Physiotherapist, Occupational Therapist

Treatment

Since mentally retarded individuals often have multiple handicaps, and in addition are subject to the same accidents, illnesses and emergencies as other individuals, it is of major importance that all malformations, physical handicaps and similar conditions be corrected by surgical, medical, dental or other appropriate therapy. Local arrangements should be made to care for every possible case, and appropriate sources of service must be available to the mentally retarded from sparsely populated areas, and for very complicated cases. Whenever specific treatment can be of value, the necessary arrangements should be made by or through the clinic in cooperation with local authorities. Routine health services will continue to be provided by community professionals and facilities.

Training

A quick glance at the personnel required for the *basic* clinic service indicates the massive training effort that must be made. Needed personnel must be developed within our own state. Florida is ten years overdue, and cannot tolerate further lost time. Medical, dental, nursing and other professionals and technical personnel can be offered such concentrated courses, seminars, workshops and conferences as will enable them to function more effectively. Florida has two medical colleges, four residential institutions, and a demonstration project, all of which can furnish short-term training and experience to all types and levels of personnel, thus supplying us with more effective personnel within a relatively short time. And of course our colleges and universities will continue to supply us with personnel. But under the emergency conditions which confront the state, training must be streamlined and a few untried methods must be attempted if the required goals are to be reached.

RECOMMENDATIONS

Prevention

1. Adequate, up-to-date prenatal care must be provided to the expectant mother through the combined forces of physicians, hospitals and health departments. Professional personnel should acquire knowledge and skills in the latest techniques of obstetrical care through short courses, seminars and similar training programs.

2. Special attention must be given by physicians, clinics and hospitals to provide high quality prenatal, delivery and postpartum care to the "high risk" patient who is already recognizable through [illegible] experience. Again, health departments, hospitals and private practitioners have the chief responsibility.

3. Based on medical need alone, hospital care must be made freely available to any pregnant female at any time during her pregnancy, regardless of financial or residential status.

4. All newborn infants must be evaluated by an experienced attendant at the time of birth and for the following several hours, using the Apgar method or a similar method. Infants born as a result of complicated pregnancy, long or precipitous labor, those with respiratory embarrassment and those who are premature or score poorly on initial evaluation must be kept under close surveillance during the first twenty-four hours of life and should be treated skillfully at the first sign of difficulty or impending jeopardy. In all hospitals having intern or resident staff, the attendant responsible for evaluation, surveillance and treatment should be a member of the house or attending medical staff. All other hospitals should assign a nurse who has received special training in resuscitation of newborn infants to this specific responsibility.

5. Regional demonstration clinics should be established where all involved personnel can observe and learn proper care of prenatal and post partum patients and the care of the newborn.

6. Audio-Visual Aids in improved prenatal care should be provided for professional personnel. Educational films and filmstrips on Antenatal Hygiene, and Diet should be available in physicians' offices, clinics and other appropriate locations for the prenatal patient.

7. The Florida Hospital Association, Florida Medical Association, Public Health Departments and other agencies and organizations should be encouraged to adopt prenatal, delivery and post partum and infant health forms. These groups should either use forms already prepared by the American Medical Association or should develop similar adequate forms.

8. Minimal standards should be developed, and presented in manual form, for the operation of maternity service programs on an outpatient basis as well as for the promotion of *child health conferences. These* manuals of standards should be sponsored by the Florida Medical Association, Florida Association of General Practitioners, Florida Obstetrics and Gynecology Society, and Florida State Board of Health and made widely available for utilization as the standard care in all clinics, hospitals and physicians' offices.

9. Education, professional liaison and more efficient committee functioning of maternal and neonatal mortality committees should be encouraged with the Medical Profession, to improve the quality of care offered by the physician and to discourage "Meddlesome Obstetrics" and improve procedures in caring for the pregnant female and newborn infant.

10. Regional centers should be established to make genetic counseling and social casework available to those patients who are deemed by appropriate professional determination to need these services.

11. Nutritional advisory services should be made available through these regional centers. Nutritional advisers should be familiar with local food habits so that they may educate the public toward an improved nutritional status for mother and infant.

12. The public should be made aware that certain drugs, radiation and diseases should be avoided by every possible means during early pregnancy. Self-medication during the first three months should be strongly discouraged.

13. Physicians should be urged to avoid medication and special medical procedures (such as x-rays) during the first three months of pregnancy.

14. Public health and education personnel and private practitioners should improve and expand their efforts to reduce the incidence of accidents and accidental poisoning in youth — especially the pre-school child.

15. Wider application of immunization and other known preventive techniques should be encouraged, to prevent mothers and children from contracting preventable diseases which might adversely affect the intellectual development of fetus and child.

16. Health education courses must be developed at the elementary and secondary school levels to provide youngsters with basic information on sex and family life. Special attention must be given to future mothers toward basic understanding of their developmental and medical needs to prepare for effective motherhood.

17. All of the foregoing recommendations are extensions of what is already known to us or already in use. Additional funds must be made available to accomplish these goals. Medical and nursing staffs of hospitals and health departments will have to be expanded in major proportion to accomplish these goals within a reasonable period.

Case Finding

18. The public generally, and parents in particular, must be informed that help for the handicapped is available and must be urged to seek that help for handicapped children.

19. All health workers and others who deal with the public as "Helpers" (social and welfare workers, for example) should be trained to recognize abnormal signs and symptoms which might indicate intellectual handicaps in children with whom they may come in contact. Schools will ordinarily discover the borderline mental retardation cases in the course of their early educational activities, but there is a real need for *earlier* case finding in all cases since remedial action may well be easier and more effective if offered earlier.

Diagnostic and Evaluation Services: Regional Centers

20. Comprehensive diagnostic and evaluation service centers should be developed in selected areas of population concentration.

21. The basic methods of operation for these centers might resemble those of the program at the Developmental Evaluation Clinic in Miami. Changes in staffing and operations may be necessary to adapt to local conditions.

22. The basic team should consist of a physician director (a pediatrician or pediatric neurologist), a clinical psychologist, a clinical social worker, public health nurse, and necessary clerical aides. All other specialists would serve on a consultative basis rather than as full-time staff as local conditions warrant or special studies are to be undertaken.

23. Services offered by the regional centers should include a comprehensive study of each case presented, including family history, family relationships, patient history, diagnosis wherever possible, a thorough evaluation of patient, family, home and community strengths and weaknesses, an estimate of expected development and potential for the patient, and a comprehensive plan for developmental support which if properly carried out can be expected to result in maximum social adjustment and intellectual function.

24. All the regional centers, and particularly those associated with the state's two medical schools, should serve as training and observation centers for professional and technical personnel. Refresher training, short courses, workshops and other training programs of a similar nature, should be organized and function through these centers.

25. A close liaison should be established between these centers and the educational systems of the state, particularly the State Department of Education — Exceptional Child Program, in order to jointly plan, coordinate and implement educational and training programs.

Treatment

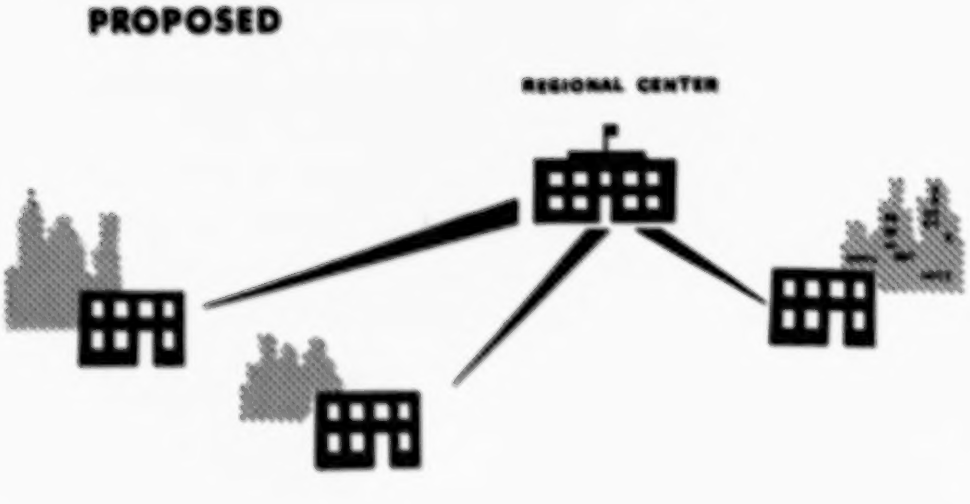
26. All correctible physical defects should be discovered and a plan should be developed for their correction either by local action or through referral to the regional center.

27. Home training and counseling plus assistance with nutritional problems should be offered by public health nursing and nutritional personnel with the assistance of other community groups prepared to offer aid of these types. The initial diagnostic and evaluative study and report plus regular support from the official agencies will alleviate many problems of affected families.

VI

COMMUNITY AND RESIDENTIAL SERVICES

CHANGES IN RESIDENTIAL CARE


PROPOSED
REGIONAL CENTER

SMALL, ACCESSIBLE CENTERS PROVIDING DAY CARE PARENT COUNSELING AND TREATMENT OF THE RETARDED CLOSER TO THEIR OWN HOMES

COMMUNITY AND RESIDENTIAL SERVICES

Introduction

From the moment a baby or child is diagnosed as being mentally retarded a conflict situation seems to exist: shall this child be provided for within his community — his home — or shall services be provided within an institution? Actually, this conflict need not exist. Parents should not feel that they must make an immediate and permanent decision, for the institution is an extension of the community and one of its resources. The child may need institutional services for a time, or hospitalization, or a period of work training, and then he may return to his family and home community. Or the retarded child, served by community programs offering opportunities for development and training, may well remain within the home until adulthood. Then, when or if the family environment is no longer available, he may enter the sheltered environment or an institution for long term training.

Approximately 4 percent of our mentally retarded are living in institutional settings; 96 percent are living within their home communities. As of January 1, 1965, Florida had an estimated population of 5,700,000. Therefore, at this time for every one million people we need care for 1,000 mentally retarded in state institutions and for approximately 25 times that many in the community. By 1970 we shall have approximately 7,800,000 residents and shall have a need for 7,800 institutional beds. By 1980 it is estimated that Florida's population will reach 11,300,000, indicating a need for 11,000 institutional beds and a need for community facilities to provide for some 275,000 mentally retarded persons of all ages. The purpose of this chapter is to assess present residential and community services for the mentally retarded, to indicate present and future needs, and to make specific recommendations of ways to meet these needs.

State and Private Residential Services

State Supported Residential Facilities

We now have in the State of Florida:	(as of May 31, 1965) **Residents**
Sunland Training Center, Gainesville	1,965
Sunland Training Center, Ft. Myers	993
Sunland Training Center, Marianna	466
Sunland Hospital, Orlando	901
	4,325

By January, 1966, an additional Sunland Training Center for the mentally retarded will have been completed in Miami with a housing capacity of 380 residents. The Sunland Centers and the Hospital are administered through the Division of Sunland Training Centers.* The Centers at Gainesville, Fort Myers and Marianna are "across the board" Centers — the residents are of all ages and all degrees of retardation. The Sunland Hospital at Orlando is a special service institution for non-ambulatory hospital-type residents.

In addition to the residents in the Centers and the Hospital, there is a waiting list of 1,620 children. And the total continues to mount as applications pour in to the Division at the rate of 75 a month or 900 a year. If all applicants were accepted, the costs to the State would be staggering. Something must be done to stem this tide of institutional placement, unless the State Legislature agrees to continue to build institutions indefinitely.

Training of Personnel

Within the state's professional schools, information on mental retardation is given both in professional nursing programs and licensed practical nursing programs. The quantity and emphasis of mental retardation training vary from school to school.

The Sunland Training Centers have orientation programs available to new employees and emphasize in-service training for cottage parents, health personnel and volunteers. 1965 Legislation will enable each Center to employ an in-service Training Director. The Gainesville Center has an eight weeks program, with one week of orientation and seven weeks of in-service training. At Marianna, their five week program is for new and prospective cottage parents. The Fort Myers Center directs its program at cottage parents and nursing personnel. The Orlando Sunland Hospital has a 15 bed teaching unit for ward employees and volunteers.

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* As of July 1, 1965, designated as the Division of Mental Retardation by legislative action.

Privately Sponsored Residential Services

Florida has more than 15 privately sponsored, profit and non-profit, residential homes or schools providing services for approximately 400 retarded children. Appropriate licensing authorities make periodic visits to these private residential facilities, to insure that adequate standards of health, safety and care are being met.

Church-Sponsored Residential Services

At present, Florida has no church-sponsored residential schools for the mentally retarded, such as are maintained by many religious groups in other states. This type of residential facility is needed in this state and should be strongly encouraged, since many parents would highly prefer a religion-oriented facility for their children.

Parent-Sponsored Residential Services

Two Associations for Retarded Children provide residential services for young adults who are in their training programs. Both provide boarding homes, supervised by house parents. More of this kind of group living arrangement needs to be fostered to allow some present residents of Sunland Training Centers to be assimilated back into their home communities.

Welfare and Child Care

Welfare: Public Assistance

Aid to the Disabled —Approximately 2,080 mentally retarded adults, 18 to 65 years, are being assisted by this part of the Public Assistance Program. There is a general lack of readily available facilities for diagnosis, evaluation and treatment. The maximum grant of $70 a month available to the disabled mentally retarded is not sufficient to meet their needs. Related to this is the problem of finding guardians for the financial management of the available grants.

Aid to Families with Dependent Children — This category of public assistance is available to families in which there is established need and in which children are deprived of parental support. As of December 1, 1964, there were 28,009 families with 85,741 children receiving this assistance. But the *maximum* grant that a family with four children may receive is $81.00 a month, which limitation obviously fails to solve all problems.

Child Care

Family Counseling — Family counseling is a crucial service in maintaining and promoting family stability in any situation which places unusual stress on parent-child relationships. This service has long been provided by the State Department of Public Welfare with emphasis on neglected children. Casework service for the retarded is geared toward making it possible for the child to remain in his own home, and various guidance services are designed to strengthen the home for the mentally retarded child.

Homemaker Service — The State Department of Public Welfare makes this service available to provide care for children in their own homes when parents are unable to provide adequate care for them. Approximately 300 children are kept in their own homes each month through this service.

Day Training — Although day training programs have usually been developed to provide for the children of working mothers, this service can be very beneficial to the mentally retarded child and his family, if it includes basic socialization training.

Foster Home Care — For the retarded child, as for other children, there is no adequate substitute for family life. When a child cannot remain with his own parents or relatives, placement with warm, understanding foster parents may be the form of care best suited to his needs. The State Department of Public Welfare currently provides foster home care for 3,200 children, including mentally retarded children. However, limitations of funds and available staff make it impossible to provide foster home care for all children who need it.

Adoption — The adoption placement program of the State Department of Public Welfare was not started until October, 1963. Therefore, the number of children served has been small. Nevertheless, it is hoped that the service can be developed to include retarded children for whom adoption would be the best plan.

Home Training Programs

Learning that their child is mentally defective is for a majority of parents a crisis situation so intense that old problem-solving methods are no longer effective. To alleviate these crises, 22 out of 27 urban areas checked had some type of home visitation plan, usually carried out by the public health nurses. Sixteen Associations for Retarded Children have programs whereby selected members and staff, though often untrained in counseling methods, regularly pay home visits to parents of infants and young children. However, only five of these urban areas had organized even limited home-training programs through the Associations for Retarded Children to help parents understand levels of development, or to teach them ways to cope with day-to-day problems of toilet training, self-feeding, educational play, motor skills and speech development.

The most acute need of the parents of the young retarded child is someone to talk with who understands. Most parents of retarded children need professional casework services and can profit from them. And the earlier these parents are offered supportive services and given authoritative information, the earlier they are introduced to other parents who have met the problem with courage, the better will be the adjustment.

Home training programs, often with therapeutic as well as educational benefits, must follow this initial counseling. Home training can be offered by a variety of professionals involved in the care of the handicapped. Staff members of the Division of Mental Retardation, Public Health Nurses, Social Workers and Child Development Specialists, for example, can provide a helpful and significant service to both child and parent.

Religious Programs

The desire for spiritual comfort and strength is freely discussed by parents of retarded children. The informed clergyman can be of immeasurable help to families at the several periods of crisis they will encounter during the lifetime of the child who is retarded. The primary need, then, is for members of the clergy to become better versed in the subject of mental retardation.

Recreation and Camping Programs

Recreation

Depending on the training and the attention span of the retarded child many spectator pleasures may be enjoyed by the retarded, and in fact the mildly retarded may often participate in regular recreation programs provided by municipalities. Usually, though, special programs are needed for the moderately and severely retarded, and although many civic clubs, and youth, fraternal, church and other groups do provide occasional socials, parties and dances for the retarded, such opportunities have been made available to only a few of Florida's retarded citizens. They should surely be made available to all, as a vital component of their treatment and training.

Public recreation directors throughout the State should fulfill their responsibility to provide recreational opportunities for *all* people in the community. Programs are presently inadequate because of lack of understanding of the retarded, limited staff, and limited budgets, among other reasons, but trained recreational personnel should make every effort to overcome these lacks and should include as large a percentage as feasible of the community's retarded children and young adults in recreational programming.

Camping

Though camping programs for the retarded have long been stressed by the National Association for Retarded Children, local camping programs have been slow to develop. In Florida, the camping opportunities that have been made available to the retarded have largely been initiated by parents and volunteers, not by leaders from the field of recreation and camping.

The Sunland Training Centers have realized the values to be gained from a well-planned camping program, and the Centers have provided such camps for their residents for many years. However, only a small percentage of the state's retarded have received any camping experience because of the scarcity of publicly operated camps and because of the expense involved in attending one of Florida's private camps.

RECOMMENDATIONS

Public Residential Services

28. An allocation of state and other public funds should be made in the form of community grants to develop and maintain public and private sponsored non-profit comprehensive community programs. This will reduce the necessity for costly residential institutional care.

29. To assure that a genuine need exists for institutionalization in the infant and young child group, appropriate counseling services, such as the social work department of the Sunland Training Centers, should be strengthened, to provide pre-application studies and pre-admission counseling.

30. A plan should be devised before July 1, 1966, whereby the populations of the Sunland Training Centers may be re-evaluated, to determine those persons now residing in centers who might be more appropriately cared for in some other setting.

31. Additional units of Sunland *Hospitals*, not to exceed 500 beds, should be built near population centers, as needed. These do not need to be self-contained hospitals; contractual services should be arranged with surgeons, physicians and other medical professions.

32. Additional Sunland Training Centers, not to exceed 250 beds, should be built in population centers where community centers are lacking, with due consideration being given to the "Standards on Residential Facilities" established by the American Association on Mental Deficiency. These additional facilities should provide daily living programs, half-way houses and various other services not now routinely supplied by Sunland Training Centers.

33. Legislation should be enacted to enable retarded children residing in a county where a Sunland Training Center is functioning to benefit from the Centers' Activities-of-Daily-Living program, while continuing to reside at home.

34. Group care homes should be established under both public and private auspices to see what can be done for a small, select group of older retarded who have the capacity to benefit from this type of care.

35. The Southern Regional Education Board should be asked to make a feasibility study and recommend a plan for a southeastern regional facility to care for retarded persons with multiple handicaps.

36. A study should be made by the Division of Mental Retardation to determine a feasible means of allowing resident transfers on a one-for-one basis, to accommodate parents moving to Florida who might want to transfer their retarded child to a Florida institution.

Private Residential Services

37. Community groups that make short term residential care available to retarded children should work closely with local departments of health, welfare and other agencies concerned to assure that proper standards for foster home care are maintained in such residential placements.

38. Officials of church, fraternal and other non-profit groups should be strongly encouraged to build residential homes in Florida as foundations or corporations to insure continuity of services throughout the life of each child.

Welfare and Child Care

39. The State Department of Public Welfare should be appropriated funds for the expansion of its statewide program of Foster Home Care for all mentally retarded children who need such care.

40. The State Department of Public Welfare should be appropriated funds for the expansion of its Homemaker Service Program, to include substitute mothers for temporary emergency duty in homes having a mentally retarded child requiring this service.

41. Day training, or "Activities-of-Daily-Living" (ADL), programs should be provided for persons who cannot attend a regular school or who are unqualified for special education pre-school programs.

42. Consideration should be given to making the State Department of Public Welfare's Adoption Program more widely available to those retarded children for whom adoption would be the best plan.

43. Maximum grants to all public assistance recipients, including those who are mentally retarded, should be increased, as should grants for nursing home care for retarded requiring this service.

Home Training and School Readiness Programs

44. Pre-school programs should be developed to supplement Activities-of-Daily-Living Centers operated for children of working mothers.

45. Appropriate universities should provide models of good nursery school programming and training of nursery school educators.

46. The State Department of Education's Exceptional Child Section staff should include a nursery school specialist or consultant who would develop and encourage constructive nursery school programs within the communities.

47. High school graduates and college students should be used in nursery school programs during summer holidays, both to help children and to motivate these students toward this field of work.

48. Appropriate professional counseling services should be made available to parents in medical or hospital settings, diagnostic facilities, community agencies and school programs.

Religious Programs

49. Institutes should be held at strategic areas throughout the state for clergymen of all faiths, to provide:

   a. Practical methods of teaching religious concepts in special classes in their churches, parishes or synagogues;
   b. Methods whereby the retarded might be included in the social and organizational programs within the religious community;
   c. Factual information regarding mental retardation, so that the clergy may more ably counsel with parents of retarded children.

50. The institutes would encourage clergymen to:

   a. Offer counseling to families requesting religious counsel;
   b. Publish papers regarding religion and its relationship to the retarded, in order to impart a broader understanding to other clergymen.

Recreation and Camping Programs

51. Recreation programs and other youth activities should be open to the retarded by program sponsors.

52. The Division of Mental Retardation should be responsible for supplying program sponsors with the newest materials and pertinent literature on recreation for the retarded.

53. Consultants from university departments of physical education and recreation should observe recreational programs within Sunland Training Centers and in local communities, to better relate the curriculum of each university to the needs of the retarded.

54. Every available means should be sought to provide camping experiences for the retarded:

- a. Communities should sponsor day camping programs, whose staff should be trained in mental retardation;
- b. Sponsors of existing residental camps should be strongly encouraged to offer one of their camping periods for the retarded;
- c. Sunland Training Centers should be encouraged to extend their camping periods to offer camping on an out-patient basis;
- d. Communities should offer "campships" to send the indigent or underprivileged retarded child to camp.

Training

55. Special Scholarship and Educational Leave programs should be made available for supervisory and key staff members of residential and community programs, who would then carry through with in-service educational programs.

56. Special institutes should be held at University Centers, Sunland Training Centers and other resource locations for community persons whose work brings them into contact with the mentally retarded.

57. Special workshops, financed by the Division of Mental Retardation should be held at Universities, Sunland Training Centers and within outstanding community programs to attract and train a large, well-qualified corps of volunteers, including retired skilled personnel.

58. Audio-visual materials should be prepared portraying the complex functioning of comprehensive services for the retarded and shown to a wide variety of groups for the purposes of education and recruitment of personnel, both staff and volunteers.

59. Statewide workshops should be developed for all personnel involved in the care of the retarded. As personnel gain more competency

through training, merited salary increases should be granted based on performance after training.

60. Each professional school should broaden courses on mental retardation in its curriculum.

61. Findings of the Southern Regional Education Board's "Attendant Training Project" should be utilized by all institution administrators.

Standards

62. There is considerable knowledge available in the field of community and residential service which is not being put to maximum use. Institutional and other administrators should make every effort to utilize this available knowledge, especially the wealth of standards which have come to be accepted and recognized in this field.

VII

SPECIAL EDUCATION, TRAINING REHABILITATION AND EMPLOYMENT

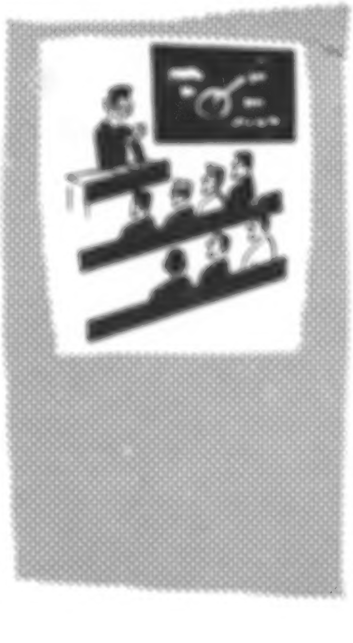
ENRICHED PROGRAM OF SPECIAL EDUCATION FOR THE RETARDED

IN PUBLIC AND PRIVATE SCHOOLS

SPECIAL EDUCATION CLASSES

VOCATIONAL GUIDANCE
& WORKSHOP CLASSES

EXTENSION COURSES FOR ADULTS



SPECIAL EDUCATION, TRAINING, REHABILITATION AND EMPLOYMENT

Introduction

The state is responsible for the education and training of every school age child who is capable of benefiting from an education and training program, even though he may have some physical or mental limitations or emotional problems. Long ago, Florida recognized this responsibility to the mentally retarded and thus in 1921 was established the Florida Farm Colony for Epileptic and Feeble Minded at Gainesville, now known as the Sunland Training Center.

Florida has made great strides in developing education and training programs for the mentally retarded since this early beginning. Nevertheless, studies show that Florida is still serving less than half of those needing service. Approximately 16,000 retarded children are being served through the Exceptional Child and Sunland programs. Though there is an education and training program in Florida, it is estimated that 20,000 children are not receiving the education and training they need.

The Florida Education and Training Program

Identification and Evaluation

Although a small percentage of the mentally retarded population can be identified early in life, the majority do not exhibit enough deviation from normal development to be suspected until they enter school; then their limitations become evident. Through the Exceptional Child Program during the 1963-64 school year, 57 evaluators in 25 county programs evaluated 15,174 children. But services are not adequate for the demand. There is a need within the school program for more extensive educational and psychological evaluation of the mildly retarded. The school program should be adequately staffed to provide psychologists and psychometrists who could test and evaluate as well as counsel with parents and perform other psychological services. Large counties could support such personnel within the county; sparsely populated areas might establish multi-county programs.

Preschool Program

Although Florida can legally serve children as young as three years, through its Exceptional Child Program, few programs for the retarded have been developed at the preschool level. For one thing, few children who are mildly and moderately retarded have been identified during their "preschool" period. For another, the pressure for special education services has focused on the age range of 11 to 14 years, where the problems have become more obvious.

But observation and research indicate that the preschool years are crucial to a large percentage of moderately and mildly retarded children; in many cases a large portion of their intellectual limitation is related to their environmental limitation. Available evidence would indicate that we should focus greater attention on the retarded of this age group since enrichment of the environment during the preschool years seems to pay the greatest dividends.

Trainable Retarded

Since 1954, Florida has been providing instruction for trainable mentally retarded children. During the 1963-64 school year, for example, 77 teachers in 22 counties provided instruction for 1,295 trainable mentally retarded children. In several areas of the state, adjoining counties are cooperating to provide adequate services, and several of the large counties are accepting children from adjoining counties without programs.

Elementary School Programs

Presently, 64 of Florida's 67 counties have one or more classes for mentally retarded children in the 8-14 age range. Unfortunately, few of these children can look forward to a continuous program through the secondary age range.

Secondary School Programs

Severe limitations in financing since 1959 had stopped development of Florida's Exceptional Child Program until recently. However, the program has begun to develop significantly of late at the junior and senior high level. Several counties have programs which continue through junior and senior high school and culminate in a certificate or diploma. A truly comprehensive training and education program for Florida's mentally retarded would provide in every county for twelve years of school, followed by placement and proven performance on a job.

Work-Study Programs

These programs provide for a part-time special class and a part-time supervised work program. Most of the schools whose programs for the mentally retarded extend through senior high school age have these programs, often assisted by vocational rehabilitation personnel.

Vocational Rehabilitation — Cooperative Agreements

The 1963 session of the Florida Legislature made provisions for the Division of Vocational Rehabilitation to enter into cooperative agreements with local school systems to develop programs for the mentally retarded. The vocational rehabilitation counselors and exceptional child teachers work as a team in the education, training, counseling, placement and follow-up of mentally retarded youth. Their united effort is directed toward developing those skills and attitudes that will lead toward gainful employment.

Counseling for the Retarded in the Public School

Counseling is needed at various times and in various degrees throughout the school-age life of a child. Any quality program for the retarded assumes that counseling will be available for the individual and his family.

A serious need in this field is for personnel. Particularly needed are qualified persons who can function in the community, when problems are first suspected. Once a child is diagnosed and placed in a school program, constant contact is made with the child and his parents and as a result, counseling opportunities are significantly increased. Qualified personnel at this level are particularly important, since it is at this level that harm can be done by friends and well-meaning professional people who are forced to assume a counseling role due to the absence of specifically trained persons in each community.

Adult Training

The term "sheltered workshop" has become a catch-all for every facility for the handicapped - from simple arts and crafts day-care to fully developed evaluation and training programs. It is often thought of solely as a setting created to provide gainful employment for the disabled. Definitively the term suggests protection, production and terminality.

Therefore, with expanding multiple services, the terms should be more carefully used and a full program for adults should be something more than a sheltered workshop. A comprehensive program for retarded adults must certainly *include* the sheltered workshop as one part of the complex in urban areas; in rural or less populous areas it may be the only service practicable.

Based on these semantic refinements, and assuming that the ideal situation of having available special classes and habilitation services through age 21 will be achieved, effort must be taken to provide such comprehensive post-school programs and services for the adult retarded that will be more than just providing employment opportunity.

VOCATIONAL REHABILITATION

Vocational rehabilitation is a program to assist handicapped persons, including the mentally retarded, to obtain gainful employment.

Civilian vocational rehabilitation began in the United States on June 2, 1920, and Florida took advantage of this national program in the State Department of Education on September 1, 1927. However, it was not until July 6, 1943, with the passage of Public Law 78-113 which greatly broadened the scope of rehabilitation, that the mentally retarded became legally eligible for vocational rehabilitation services.

In 1945, two mentally retarded persons were habilitated through the Division of Vocational Rehabilitation of Florida. Personnel in Vocational Rehabilitation, both State and National, generally knew little about mental retardation in the formative years of this new phase of the program and there were few, if any, community agencies for this group.

For the fiscal year 1963-64, Florida habilitated 179 mentally retarded persons, leading all states in Region IV of the United States Department of Health, Education and Welfare in the total number of mentally retarded persons served.

Earnings of these 179 persons (124 men and 55 women) amounted to an estimated $296,140 annually. Most of these were young people. Only seven of them were over thirty-four years of age.

The fifteen District Offices of the Division of Vocational Rehabilitation in Pensacola, Panama City, Tallahassee, Jacksonville, Gainesville, Daytona Beach, Orlando, Rockledge, Bartow, Tampa, St. Petersburg, Sarasota, West Palm Beach, Fort Lauderdale and Miami are providing services to a limited degree to the mentally retarded, dependent upon funds and personnel available for the total job to be done.

Close cooperative working relationships have been established throughout the State with voluntary organizations operating sheltered workshops or other rehabilitation facilities for the mentally retarded.

EMPLOYMENT

At the present time the Florida State Employment Service has approximately 55 selective placement interviewers and counselors working throughout the state with both the physically and mentally handicapped worker. These interviewers and counselors are familiar with the problems revolving around the placement of the mentally retarded; they know what occupations the retarded are best suited for, and they are aware of factors affecting employer acceptance and resistance.

Since there have not been large numbers of mentally retarded ready for employment, the Employment Service has been able to maintain a successful employment program. However, the recent intensification of effort on behalf of the mentally retarded will probably create a considerable increase in the number of mentally retarded applicants seeking employment and assistance in the very near future. It would seem appropriate to begin expansion of the Employment Service Staff, especially the job development personnel, in anticipation of the imminent need.

RECOMMENDATIONS

Identification and Evaluation

63. A plan for appropriate financing of school psychologists and psychometrists should be developed for inclusion in the Minimum Foundation Program. The plan should provide both for services in large counties and for cooperative arrangements between less populated areas. The plan would follow one of three directions:

- **a. Developing special units for school psychologists, school psychometrists and school social workers;**
- **b. Changing the ratio of *ASIS** units from 1/8 to 1/6 in order to make funds available for such personnel;**
- **c. Requiring that *ASIS* units earned by the Exceptional Child Program be used for psychological evaluation, social work and related services to exceptional children.**

64. A close liaison and working relationship should be developed between school evaluation services and community diagnostic and evaluation centers.

Preschool Program

65. The State Department of Education through local school systems should take the initiative in developing several demonstrations and

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* Administrative Special Instructional Service Units

research projects for children who lack a stimulating home environment. These projects should provide for:

a. Development of tools for early identification of children who could benefit most from a preschool program;

b. Development of curriculum and materials;

c. Longitudinal study of results of the program;

d. Study of training needs of personnel to staff these programs.

66. The results of the programs should be publicized to acquaint legislators and general educators with the financial values of the program.

Education and Training

67. In order to guarantee a basic educational opportunity to all children, including the exceptional child, the Legislature should fully implement the Minimum Foundation Program, by providing exceptional child instruction units to school systems as provided by Section 236.04(4), Florida Statutes.

68. Additional staff should be provided in the Exceptional Child Section of the State Department of Education to:

a. Provide necessary leadership for program development within each county and between counties;

b. Develop materials and provide consultant service to teachers for curriculum and methodology at the various age and ability levels;

c. Provide leadership in research, demonstration and evaluation of instructional and curriculum problems through utilization of available research funds;

d. Provide services in areas related to mental retardation, i. e., speech, hearing, vision.

69. Cooperative projects between the Division of Vocational Rehabilitation and other services should be increased, so that quality programs can be developed throughout the senior high schools. These projects can be fostered by supporting recommendations 67 and 68.

70. To facilitate the transportation of the educable and trainable mentally retarded to appropriate centers, the recommendations of the State Department of Education for the revision of transportation laws and regulations should be supported.

71. The practicality of using VISTA (Volunteers in Service to America) personnel and work-study vocational aides as teaching aides and teaching assistants should be explored.

72. In order to expand and develop the programming for trainable,

preschool, primary, intermediate and secondary levels, the State Board of Regents should initiate a study of teacher training programs in exceptional child education. The study should be directed toward a State Plan that will supply the Florida programs with the quality and quantity of graduates necessary to staff a quality program of education and training of retarded and other exceptional children.

73. Research projects should be encouraged to:

- **a. Study the development of a junior college program for training teaching assistants and teaching aides for the trainable mentally retarded.**
- **b. Develop longitudinal studies on expectations of the trainable mentally retarded.**

Vocational Rehabilitation.

74. The State Budget Commission should approve and the Legislature should make available to the Division of Vocational Rehabilitation the funds necessary to fully match federal funds to rehabilitate the handicapped.

75. The Budget Commission and the Legislature should approve the additional positions necessary to fully implement the program of the Division of Vocational Rehabilitation.

76. The Division of Vocational Rehabilitation should work closely with the Sunland Training Centers. Sufficient vocational rehabilitation staff should be provided to encourage cooperation between the Division of Vocational Rehabilitation, the Sunland Training Centers and all interested community agencies.

77. Consideration should be given to the construction of dormitories and other necessary rehabilitation facility buildings at selected vocational schools in Florida. Consideration should be given to the use of Hill-Burton funds for this purpose.

78. Persons awaiting admission to Sunland Training Centers should be evaluated to identify those who may be potential rehabilitation clients.

79. Consideration should be given to including a vocational rehabilitation counselor as a member of an evaluation team to study all mentally retarded applicants for the Sunland Training Centers who may have rehabilitation potential, to determine whether there are sufficient services and resources outside the Center for satisfactory vocational rehabilitation of the applicants.

80. Chapter 59-385, Laws of Florida, authorized the Division of Vocational Rehabilitation to administer a program of self-care rehabilitative services for the severely handicapped, including the mentally retarded,

and also authorized the rendering of evaluative services above and beyond the ordinary services for rehabilitation purposes. This Law has never been funded. Funds should be appropriated to activate this Law, which would enable the Division to cooperate with related agencies in developing this program.

81. An extension of special education classes in county school systems for pre-rehabilitation training would be helpful to the mentally retarded. The Legislature should provide funds for additional classes and additional coordination of the classes through full implementation of the minimum foundation program.

82. The Division of Vocational Rehabilitation should continue to develop and increase the number of cooperative projects with exceptional child programs in county school systems for the total training and placement of handicapped youth.

Counseling

83. Pre-service and In-service Training Programs should acquaint appropriate personnel (such as exceptional child teachers, administrators and supervisors, persons responsible for care and treatment) with community services and instructional programs available for the mentally retarded. Such programs should place greater emphasis on opportunities for the mild retardate who has potential for training and rehabilitation within the community.

Adult Training

84. A program of post-school services for the retarded should provide work evaluation, occupational training and placement, sheltered employment and recreational programs for each retarded citizen needing one or more of these services. These habilitation centers should be totally available regionally, with satellite units placed where needs appear but relating to the regional center for overall correlation of evaluation and training.

85. New services should be geared to the community and should not duplicate services already available. Before new workshops or habilitation services are initiated, the community should be surveyed to see whether the retarded may benefit from existing habilitation centers.

86. We recommend the multiple disability workshop. To meet community needs, the multiple-disability concept of inter-training or inter-employing people of varying handicaps should be in effect.

87. If social and recreational outlets have not been provided by another agency, the habilitation center should provide such services,

but only after work hours so that they will not present an inappropriate picture of recreation in a work setting.

88. Residential facilities as an adjunct to a habilitation center are needed as a temporary "home away from home" for those participating in evaluation or training and needing "Foster Parent" type care for strengthening personal adjustment, and for those whose permanent residence is of a distance not feasible for daily commuting. This type of boarding or residential facility should provide realistic training in food services, housekeeping and maintenance, laundry and such other work training likely to present employment opportunities.

89. Residential facilities should also be provided for those who, upon completion of training, are capable of working and functioning in the community but who need a family image home to return to daily. This type of facility would offer a minimum of supervision and would afford the habilitated client an opportunity to function as independently as feasible.

90. Comprehensive community habilitation centers should be supported financially by adequate funding of the official agencies who normally refer retarded citizens and purchase the services offered by the facility, combined with community financial support and proceeds from the production projects of the program.

91. The state should provide funds, through appropriate agencies, to assist in the construction of community habilitation facilities for the retarded.

Employment

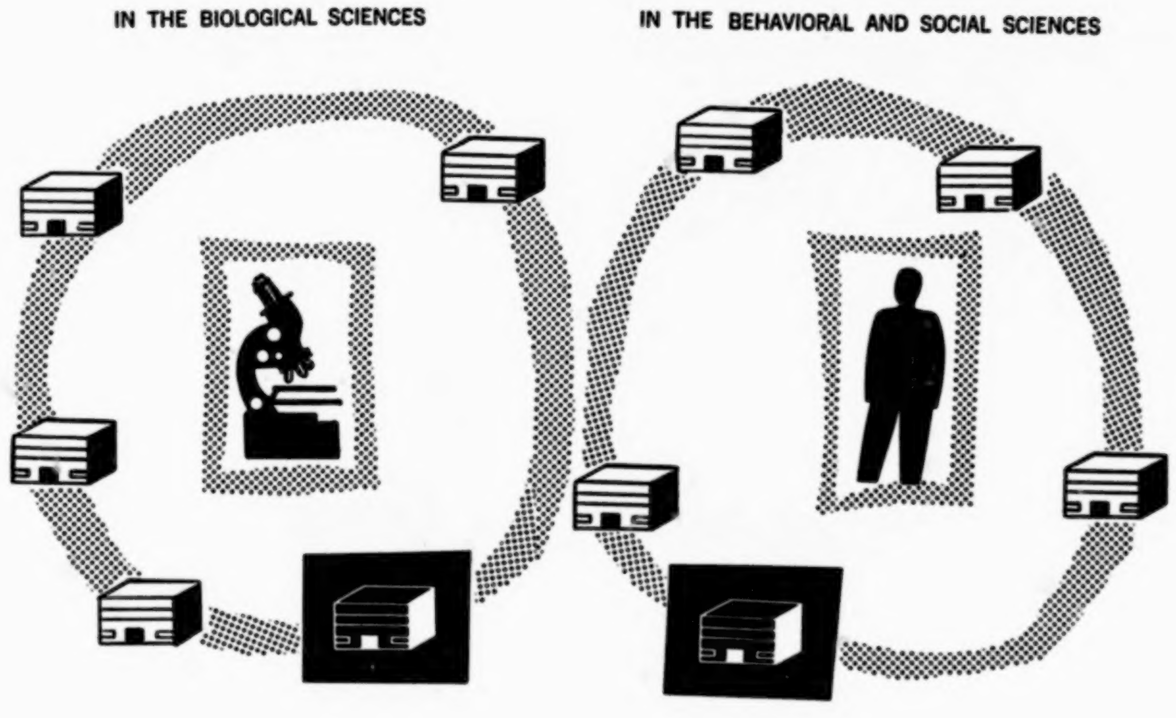
92. The Employment Service's greatest need is additional staff for the soliciting of jobs for the mentally retarded.

93. Funds should be allocated to the Employment Service so that sufficient selective placement interviewers may be provided for job development and placement of handicapped persons, including the mentally retarded. These personnel should receive special training in the placement aspects of mental retardation.

VIII

RESEARCH

RESEARCH CENTERS


IN THE BIOLOGICAL SCIENCES
IN THE BEHAVIORAL AND SOCIAL SCIENCES

ALL SHOULD COOPERATE AND SHARE FINDINGS

RESEARCH

Introduction and Current Status

Research in mental retardation encompasses any activity or study which provides meaningful information concerning problems that are pertinent to the understanding of prevention, diagnosis, treatment, training, causes or amelioration of causes of mental retardation. Research, therefore, involves investigations of the medical, behavioral and educational aspects of mental retardation. Continuing research — both basic and applied — is crucial to prevent and more effectively treat the mentally retarded.

The President's Panel on Mental Retardation has recommended that high priority be given to the development of research centers at strategically located universities and at residential facilities for the retarded. The general purpose of such centers would be to conduct basic and applied research in the laboratory and in the field. Florida is in a good position to develop such research centers. At its state universities are located many of the specialized personnel required to conduct research. Moreover, a modest research program has been initiated within the Division of Mental Retardation.

It is only through research activities that any ultimate hope of significantly reducing the numbers of the mentally retarded can be maintained. Furthermore, it is only through research that treatment and training programs for the retarded can be adequately evaluated and improved. There is a vital need in Florida to intensify research activities in mental retardation. Research into the causes of mental retardation are urgently needed; such research requires an interdisciplinary team, including physiologists, embryologists, pediatricians, neurologists, biochemists, obstetricians, pathologists, social workers, psychologists and educators. Briefly, there are few conditions in medicine to which a wider range of interests and research skills are applicable than mental retardation. Moreover, there are few conditions which offer more promise for useful discovery than mental retardation at the present time.

Basic research can be best conducted in a university setting because so many of the related specialities are concentrated there. The Sunland Training Centers house a large number of cases. Moreover, the special classes in the public schools contain ever greater numbers of retarded children. These three sets of circumstances should be combined, where possible, into a successful research program. Specifically, the universities can utilize the Sunland Training Centers and the special classes in the public schools for case material and the special classes in the public schools and the Sunland Training Centers can utilize the special consultative services of the universities.

Although, a few researchers are actively investigating the medical aspects of mental retardation in Florida, the potential for such research is barely being tapped because of shortages of funds, personnel and lack of wide-scale commitment to research in mental retardation at the universities and elsewhere. There is a vital need to expand Florida's resources so that research in mental retardation can be intensified.

Behavioral research is of equal importance to the advancement of knowledge about mental retardation. Evidence is continually accumulating which suggests that the inadequate behavior of many children can be attributed to certain adverse factors in the experiences of the child rather than to biological and nutritional factors. The evidence is strongly suggestive that these experimental factors are especially operative in the so-called "culturally deprived" child. More precisely, it appears that many children are "mentally retarded" because of the particular combination of experiences to which they have been exposed. The possibility of preventing and ameliorating mental retardation by manipulating the experiences of children calls for long-term psychological, sociological and educational research. Basic and applied research will be needed to identify the factors which result in an individual being mentally retarded (frequently referred to as "functional mental retardation") even though no physical abnormality can be demonstrated. (The current emphasis on the eradication of poverty by the Federal Government has a direct bearing on the problem of "functional mental retardation" because available data indicates a high evidence of such retardation in a chronically depressed and slum area and among individuals in low income brackets.)

As in medical research, there are a few researchers in Florida actively engaged in behavioral research relating to mental retardation. The potential for such research goes largely untapped because of lack of financial support, lack of personnel and lack of commitment to research in mental retardation at the universities, the public schools and elsewhere.

RECOMMENDATIONS

As previously noted in this report, it is only through research activities that any ultimate hope of significantly reducing the numbers of the mentally retarded can be achieved. Furthermore, it is only through research that treatment and training programs can be adequately evaluated and improved. While isolated, beginning research efforts have been initiated in mental retardation in the medical and behavioral spheres, these efforts need to be greatly expanded, intensified and coordinated. The following recommendations, when implemented, should provide Florida with a research program in mental retardation which will, hopefully, shed valuable insights into the problem noted above:

94. Basic Science and Basic Science Research Centers at the universities should continue to be supported and expanded.

Many research specialists, although not directly involved in research in mental retardation, may by their findings advance general knowledge in the field of mental retardation. The geneticist, pathologist, chemist, learning theorist, physiological psychologist, sociological theorist and others may discover principles that are particularly important for mental retardation despite the fact that mental retardation is not their special problem of concern. This recommendation can be implemented by an expansion of appropriate personnel at the universities. Expanding university staffs would not only make it possible for university personnel to conduct more research but would also facilitate the training of a great number of persons capable of doing research in areas relevant to retardation. Concurrently, time should be made available and encouragement should be given to professionals at the universities and state institutions to conduct research.

95. High priority should be given to the development of one or more child study centers for the retarded; such centers to be under the auspices of a university or college.

Such centers should be staffed with fully qualified educational, psychological, nursery, social work and medical personnel so that a coordinated demonstration service for the mentally retarded can be provided. Action research and a superior training resource for personnel preparing for work with the retarded could be realized in such a setting.

96. Provisions should be made for the construction of research

facilities at the Sunland Hospital and one or more of the Sunland Training Centers. (Federal funds are available to assist in the construction of such facilities.)

These facilities should be specifically identified as research facilities and should function independently of the service facility.

97. The hospitals at the Sunland Training Centers, particularly at Miami and Gainesville, should meet at least minimal requisites for hospital accreditation.

This recommendation is especially compelling for the Centers at Gainesville and Miami so that staff, interns and residents at the medical schools could function in these Centers.

98. Financial support should be provided for a variety of research and demonstration projects in all aspects of mental retardation.

Demonstration and evaluation of newly established programs are important aspects of a total research program. As previously noted in this report, there is a need in Florida for demonstration projects related to the development of appropriate programs for those children who lack stimulating home environments. Moreover, there is a need for funds by investigators to enable them to conduct pilot projects so as to develop research plans which can attract research grants from private foundations and the Federal Government. Funds for pilot projects, thus, can serve as "seed money" for the attraction of large scale grants from agencies other than State governments.

99. A director of research should be established in the Division of Mental Retardation.

The director should be a qualified, professional scientist in the medical or one of the behavioral fields and should have demonstrated his competence in conducting research in mental retardation or related fields. The director would not necessarily — and such probably would not be desirable because of isolation from the subject matter being studied — be located at the central office of the Division of Mental Retardation.

100. A coordinator of research should be appointed at each of the institutions coming under the aegis of the Division of Mental Retardation.

The coordinator of research should be a professional scientist and should have qualifications similar to those of the Division's Director of Research.

By the appointment of a Division Research Director and a Coordinator of Research at each of the institutions in the Division of Mental Retardation, coordination of research both within and without the Division should be attained.

101. The State Interagency Committee on Mental Retardation should take responsibility for the promotion, expansion and coordination of research in mental retardation in Florida.

It is recommended that the State Interagency Committee on Mental Retardation should appoint a Research Council which would make recommendations to the State Interagency Committee on Mental Retardation for developing and insuring the coordinating of research in Florida, and throughout the United States and the world. Moreover, major research projects requiring interagency coordination would be evaluated by the Research Council and recommendations to the Committee as to the disposition of such projects would be made. The Research Council should be composed of members from appropriate state agencies, the medical schools, public and private universities and private organizations conducting research in mental retardation.

102. Provisions should be made for the transfer of residents between the Division of Mental Retardation and institutions of higher learning.

A flexible policy regarding transfers would facilitate clinical research — both of a medical and behavioral nature — at the universities and would make highly specialized diagnosis, treatment and training more readily available for the institutionalized, retarded child.

103. Provisions for the admission of non-institutionalized retardates and members of their families into the University Research Centers should be made. Once admitted, comprehensive diagnostic services should be provided for such retardates and their families.

Again, the purpose of this recommendation is primarily aimed at the facilitation of research in mental retardation.

For example, in investigating certain genetic factors in mental retardation, it is conceivable that exhaustive laboratory tests requiring the attention of many professional specialists would be necessary if meaningful research were to result. Provisions for such an event would greatly facilitate multidisciplinary research on a variety of "familial" disorders associated with mental retardation.

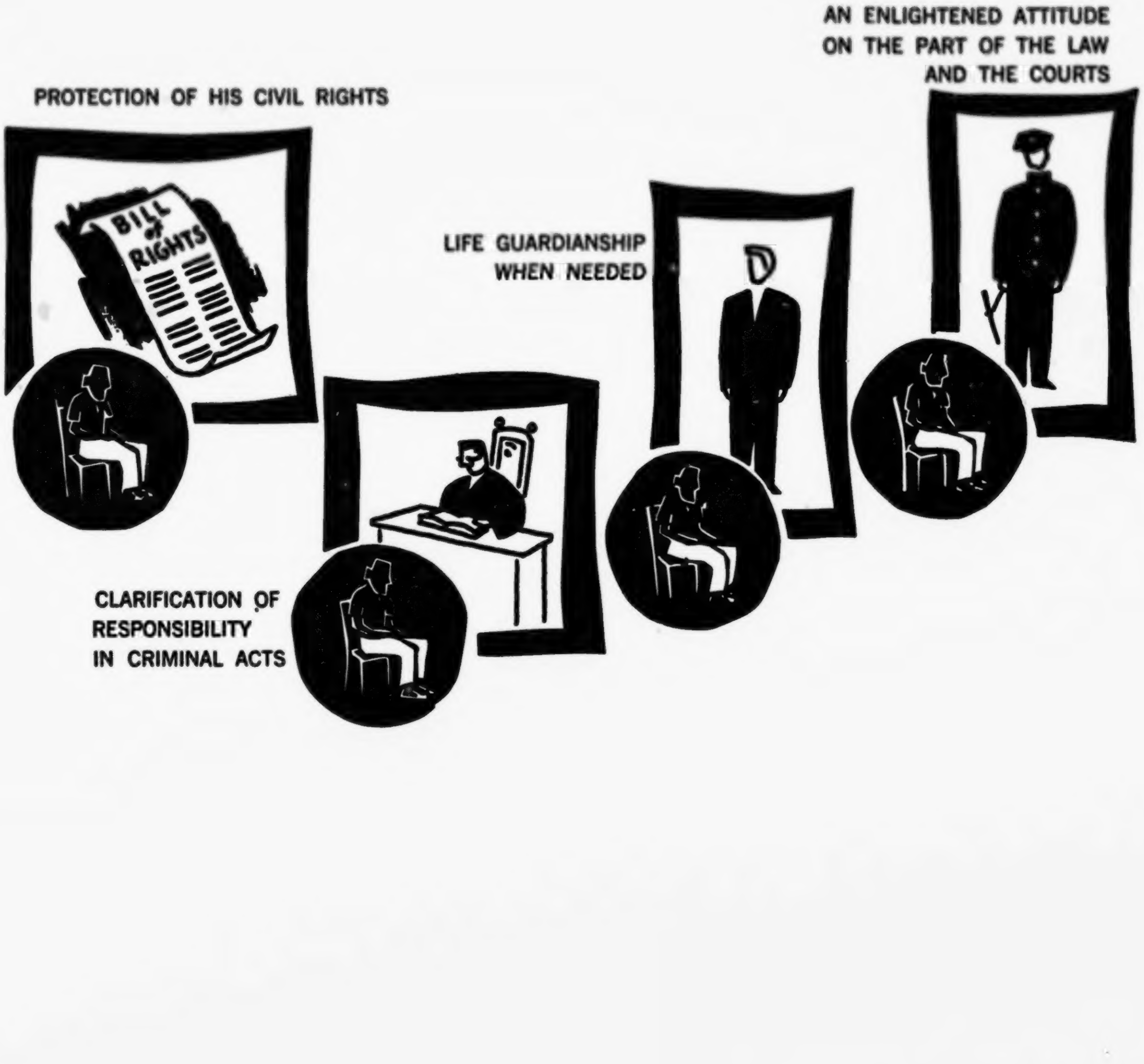
104. Plans for a central source of information about the retarded population of Florida should be developed and implemented.

Perhaps, the same central source could also serve as the "central data bank of information" concerning research related to mental retardation occuring throughout the State. Recommendations for the detailed design and implementation of this proposal would likely be readily devised by the Research Council on Mental Retardation proposed above.

IX

LAW AND PUBLIC AWARENESS

A NEW LEGAL CONCEPT OF THE RETARDED


PROTECTION OF HIS CIVIL RIGHTS
BILL of RIGHTS
CLARIFICATION OF RESPONSIBILITY IN CRIMINAL ACTS
LIFE GUARDIANSHIP WHEN NEEDED
AN ENLIGHTENED ATTITUDE ON THE PART OF THE LAW AND THE COURTS

LAW

Introduction

Mental Retardation services and facilities touch the law at many points, and legislation in several areas seems to be needed if the State Plan is to be fullfilled. It is hoped that the needed legislation will be passed by the 1967 Legislature. The changes, additions and deletions suggested below would do much toward eliminating discrepancies in the law, and toward insuring the mentally retarded the legal rights and privileges to which they are entitled.

Definition

There is disagreement as to the most useful, most accurate and most descriptive definition of "mental retardation." Several states and foreign countries use the definition advanced by the American Association on Mental Deficiency:

> Subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

This is a sound, helpful definition and should be proposed as law.

Admissions

Present law regarding admission procedure to the Sunland Training Centers seems to stand in need of revision. In light of the successful experience of other states with voluntary admission, Florida might do well to consider such admissions as well as those obtained through court commitment.

Voluntary application for minors may be made by parents or guardians in many states. In Connecticut, Virginia, Illinois, Iowa and Ohio, a retarded adult may make application himself, and in New York a retarded person may apply after he has reached the age of 18. Voluntary admission in these and other states is working satisfactorily and is well accepted. Though much study is still needed regarding such admissions, there seems to be no reason why the system should not work well in Florida, with adequate safeguards.

At present, an examination is required prior to admission to the Sunland Training Centers. But the qualifications of persons conducting the examinations have not been made clear. The law should be changed to insure that examiners are qualified to properly evaluate the condition of the applicant.

Discharge

The discharge of a resident from a center is directly related to the manner in which the resident was admitted. For example, in those states permitting voluntary admission, the person so admitted must be released if he gives notice that he wants to be released. In the matter of civil rights — such as marriage, voting and ownership of property — the type of admission and age at admission and discharge often determine whether civil rights have been affected. For example, if a child voluntarily admitted is subsequently discharged before reaching the age of 21, his civil rights have not been affected since his admission was a voluntary act with no court order involved. Should the same child be discharged subsequent to his 21st birthday, there was a period — between his becoming 21 and his discharge — during which a condition prevented his assumption of his individual, civil rights.

This situation seems to work an undue handicap on certain discharged persons, and it is probable that civil rights should be automatically restored to those who show no evidence of personal disability and indicate ability to manage their property.

Pay Maintenance

Determination of Ability to Pay

At the present time the law does not contain the proper machinery to determine the amount which parents are able to pay or how much they should pay. An agency independent of the Division of Mental Retardation, preferably the Department of Public Welfare, should establish the parents' ability to pay and the state should enforce payment. Of course, if a change in financial ability to pay comes about, adjustments would be made.

Collection of Fees for Service

If the ability of parents to pay, and the amounts they should pay, are to be determined by law, then a method must be established by law for collection in the event of failure to pay. The State Revenue

Commission should be delegated this function and should invoice and collect fees charged for services rendered to residents of the Sunland Training Centers.

Day Training Centers

The cost of care and training for a residential retarded child is approximately four times the cost for the child who attends a community day training center. Therefore, any extension of facilities that meets the training needs of the retarded and that allows the child to remain at home with his parents is of outstanding benefit to the child, his family and the state economy.

The Exceptional Child Program of the public school system is designed to meet the need of the child who can benefit from academic training and remain at home. However, there are some younger children who remain at home but do not fit in regular exceptional child classes; there are some older children who need vocational training and experience in specific work production. There seems to be a gap in such service which should be closed by extending the education and training activities of the Sunland Training Centers into programs for the day student. Thus it would be possible for a child to progress from a residential status, to a day student and to an exceptional child class. Similarly, some children in the Exceptional Child Program may be assigned to a Sunland Training Center day program because of their inability to adjust to and benefit from the Exceptional Child Program.

Mentally Retarded Offenders

Legal statutes at the present time do not properly recognize the problem of the mentally retarded offender. The law presently contains provisions to determine the mental condition of a defendant before or during trial, but such determination relates solely to matters of "insanity" (mental illness). There is no provision for determining the "mental age" of an offender. In determining the criminal responsibility of an accused, the present test used by the courts is the "right and wrong" test, which does not always give proper consideration to the condition of mental retardation.

There is need for the courts to take a broader view of the mentally retarded offender. He may know the difference between right and wrong but still may need special help, perhaps in a hospital rather that in jail. The courts should take the lead in encouraging a more liberal interpretation of the law as it relates to mentally retarded offenders.

Sterilization

Sterilization is a surgical procedure which physically prevents conception without demonstrable effects otherwise. Twenty-eight states have sterilization laws. (Florida does not have such a law.) Twenty-six of these have statutes for sterilization which are compulsory and authorize sterilization of a patient without his consent, if the statutory procedure is observed.

Most of the sterilization statutes enacted in the United States directed at hereditarily feeble minded, insane and epileptic persons, have provided for compulsory sterilization and justified on the grounds of prevention of propagation for eugenic reasons. But the problem lies in determining accurately what mental illnesses and mental deficiencies may be classed as "hereditary." In fact, it has recently been postulated that environment plays an important role in such disorders.

Furthermore, many laws pertaining to sterilization were enacted at a time when the great majority of patients were confined for indefinite periods in institutions. Since the trend now is toward more energetic management and rehabilitation, with a view toward release in the community, a re-evaluation of the grounds upon which compulsory sterilization is based should be made.

RECOMMENDATIONS

Definition

105. The following definition of mental retardation, proposed by the American Association on Mental Deficiency, should be proposed as law:

> **Subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.**

Admission to Centers

106. Regulations of the Board of Commissioners of State Institutions, providing requirements for admission to Sunland Training Centers, should eliminate the word "epileptic" inasmuch as epilepsy per se should not be a basis for admission to the Centers.

107. The requirement of a statement under oath concerning the financial ability of the parents or legal guardian to pay for the care of the applicant should be eliminated.

Types of Admission

108. A diagnostic examination should be conducted by such professional personnel as would be determined by the Board of Commissioners

of State Institutions to be best suited to evaluate the condition of the applicant.

109. A procedure should be established permitting voluntary admission of applicants, without the necessity of a judical determination.*

Discharge

110. Wherever the word "dismiss" appears in present law, relative to the mentally retarded in institutions, it should be changed to "discharge."

111. The Board of Commissioners of State Institutions should adopt rules and regulations relating specifically to discharge and furlough.

112. The Superintendents of the Sunland Training Centers, with the approval of the Director, should be authorized to discharge patients.

113. Automatic restoration of civil rights upon release, similar to the Automatic Restoration Provision contained in Section 394.22(16)(b), Florida Statutes, relating to the mental competency of persons released from the Florida State Hospital, should be considered.

Pay Maintenance

114. A method should be established to determine the ability of parents to pay, and the amount to be paid, for residential services. This determination should be made by an independent agency, such as the Department of Public Welfare, which would take into consideration such variable factors as size of the family, number of children retarded, and minimum cost of maintaining normal children at home.

115. A method should be established of collecting fees for care or services. This determination should also be made by an independent agency such as the State Revenue Commission.

Guardianship

116. There is presently no need to adopt a Guardianship Law especially for the mentally retarded because the general Guardianship Law appears to contain the necessary safeguards.

Day Training Centers

117. Legislation should be passed permitting the Sunland Training Centers to extend their training programs to day students not otherwise eligible for the Exceptional Child Programs.

118. Legislation should be passed enabling the Division of Mental Retardation to assist existing day training facilities.

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* Enacted into law by the 1965 Legislature effective May 21, 1965

Mentally Retarded Offenders

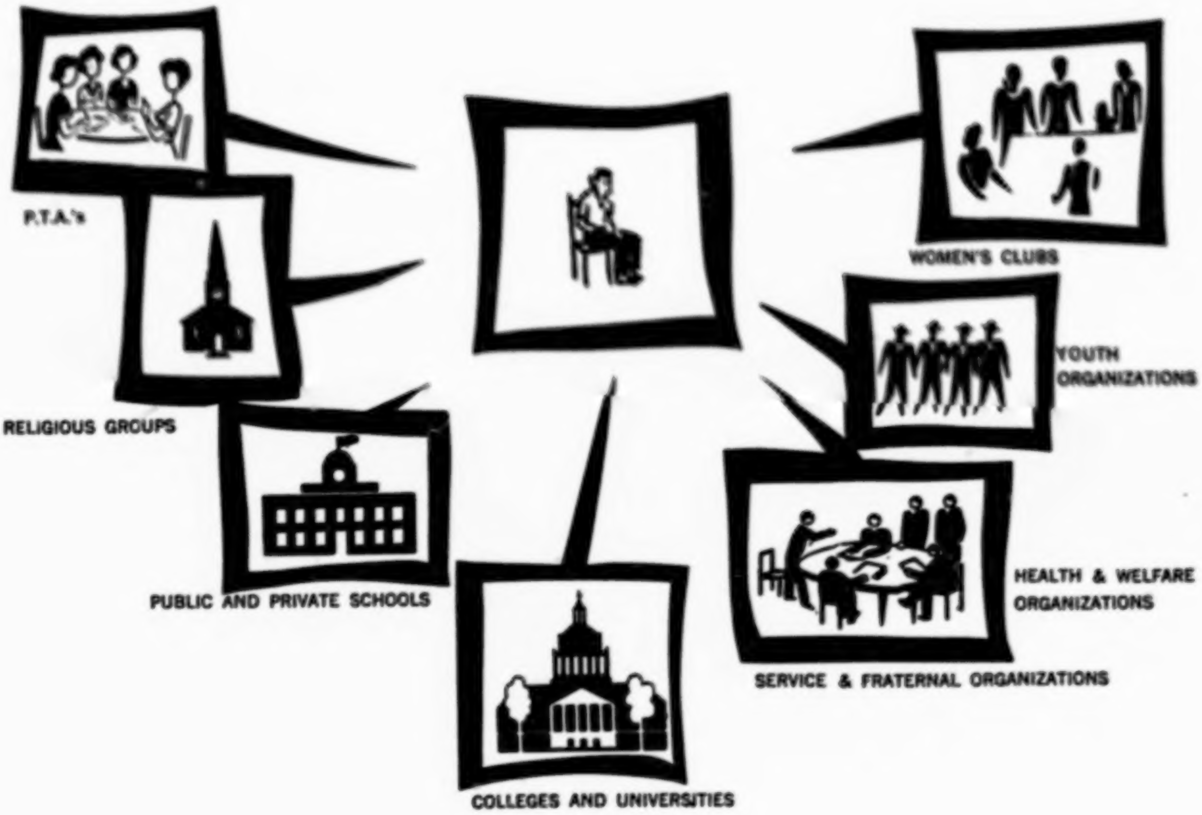
119. Present statutes relating to court proceedings to determine the mental condition of defendants should be revised by adding the words "mentally retarded," with a provision for determining the mental age of an offender as opposed to his chronological age.

Birth Regulation, Guidance and Control

120. Birth regulation, guidance and control methods should be studied as they might relate to the rehabilitation of certain mentally retarded persons. A re-evaluation of the ground upon which compulsory sterilization is based, should be made before any legislation is considered. It is questionable whether Florida legislation providing for eugenic sterilization of the mentally retarded is desirable or necessary at this time.

PUBLIC AWARENESS

DISSEMINATION OF INFORMATION
TO OPINION-MAKING GROUPS


P.T.A.'s
WOMEN'S CLUBS
YOUTH ORGANIZATIONS
RELIGIOUS GROUPS
HEALTH & WELFARE ORGANIZATIONS
PUBLIC AND PRIVATE SCHOOLS
SERVICE & FRATERNAL ORGANIZATIONS
COLLEGES AND UNIVERSITIES

PUBLIC AWARENESS

Mental retardation is not just a problem that affects the parents of mentally retarded children, or a handful of state agencies or a few national organizations. It is a social problem — everyone's problem. Broad public awareness, understanding and acceptance of mental retardation and its many personal and social implications are essential factors of a community and state program for the retarded. History has shown that an informed, aware American public is a responsive public.

Though an attempt has been made in this report to remain objective, to be reasonable rather than passionate, it is difficult to remain so; behind the dry statistics, behind the straight forward statements of need, stand the parents of mentally retarded children, the doctors and nurses, and the personnel of state and community agencies, each frustrated by the knowledge that the lack of funds and personnel prevent meeting all of the needs of the retarded.

Much has been done to encourage public awareness. At the national level, the National Association for Retarded Children, the American Association on Mental Deficiency, the Council on Exceptional Children and the U. S. Department of Health, Education and Welfare are among a number of groups concerned. The National Advertising Council has made a public information campaign on retardation its new project for two years. These groups do what they can, within the usual limitations of personnel and funds. Within the state, the Florida Association for Retarded Children, its member units and groups whose functions and activities have been explained in this report are all involved in making the public aware of the work they do and what they need to better do this work.

The Retardation Planning Office publishes a newsletter, *Concern,* which keeps information about mental retardation flowing and attempts to reflect community action for the retarded. Its Community Public Information Officer acts as a clearinghouse for useful information on retardation and disseminates material for use by radio and television stations and newspapers.

The needs are many. The facts must be made known. The size of the problem must be emphasized. The non-discriminatory character of mental retardation must be made clear — it can occur within all families of all races and all socio-economic levels. Major emphasis must be placed on the inadequacy of present services. A misinformed or an uniformed public creates negative attitudes toward mental retardation. As long as such an atmosphere of fear and non-acceptance is permitted to influence a substantial part of a community, there can be no assurance that programs for the mentally retarded will be provided or be effective if attempted. This was illustrated very emphatically by Dr. Gunnar Dybwad who stated: "There is little use in training a retarded child with painstaking effort to become socially adept and responsive — to play a game or sing or dance — if misinformed, fearful neighbors will have their children shun him and make him the outcast of the neighborhood. There is little use in teaching a retarded youth work habits, independence in getting about alone and occupational skills, however simple, if misguided townspeople, haunted by old wives' tales and superstitions, refuse to even consider that a mental handicap, too, can be partially overcome." (11).

Once the facts have been made known, once the widespread ignorance regarding mental retardation has been replaced by knowledge, then attitudes will slowly begin to change. Current resistance to proposals that the retarded have a place in the community will be weakened. The sense of guilt and shame within parents of retarded children will be lessened, the feeling that mental retardation is a mysterious stigma will disappear. And the retarded will become accepted in parks, recreation centers, churches and other social situations so necessary to their fullest development.

How do we do it? We can perhaps learn a lesson from the fact that more Floridians are aware of a recent piece of legislation prohibiting the driving of a car by a monkey than are aware of the differences between mental illness and mental retardation, or even that there *is* a difference. It is probable that more Floridians are aware of the current drought in the Everglades, with its disastrous effects on birds, bass and alligators, than are aware that three out of 100 Florida children are functioning imperfectly and that something can be done to meet their individual needs. Only a few of us know what a PKU test is. We are an informed public, but we seem sometimes to be aware of information of strange sorts.

As the preceding examples indicate, the means of transmitting information *do* exist, to a greater extent than ever before in history. These means must be utilized. We need articles in professional journals and mass readership magazines. A public speaking campaign is in order — face to face presentations before civic clubs, unions, organizations and the like, can do much. The news media are crucial to the campaign. Television and radio special programs can make statistics come to life. Existing films and scripts must be more broadly distributed. These are some preliminary steps to public awareness.

Despite these activities, the needs set forth in the various sections of this report indicate that the public has not been "reached" — there has not yet begun the ground swell of necessary public concern. Mental retardation continues to be thought of as something that happens to "somebody else."

To tell the public the story, action must be taken:

a. To alert the public to the size and scope of the problem — the fact that there are 174,000 retarded in Florida — that the problem can hit anyone — that services for them are inadequate. are inadequate.

b. To make the public aware that some retardation can be prevented — that most retardates CAN be helped if they are trained and if they are given the opportunities for employment. Detailed lists of jobs that the retarded have proved they can do — and do well — can show they are dependable workers.

c. To convince the public that the retarded are more *like* other people than *unlike* them, and kill the old wives' tales and fears which still prevent the trained retardates from being given their place in the productive community.

d. To document the successes that result when educational, recreational and habilitative services are offered the retarded, when teachers understand them and when the community — and its employers accept them. There are a number of employers who have been in the forefront in hiring the retarded and who claim that the retarded, in some cases, are their best workers.

RECOMMENDATIONS

121. A state-wide Citizen Council on Mental Retardation should be named, made up of parents of retarded children, interested citizens and professional persons, to encourage public support of state and com-

munity centered programs and to assure the citizens of Florida that these programs are providing for the welfare of their retarded. (House Bill No. 115, 1965 Legislature establishes an Advisory Council to the Director, Division of Mental Retardation — Appendix B.)

122. Every person in every agency which serves the retarded and their families in any way, directly or indirectly, should be encouraged to make public awareness about mental retardation a personal responsibility.

123. A concentrated public information and education program concerning mental retardation should be aimed at the parents of retarded children, professional groups, civic and fraternal organizations, students in junior and senior high schools, colleges and the general public using every existing media of communication to the fullest extent.

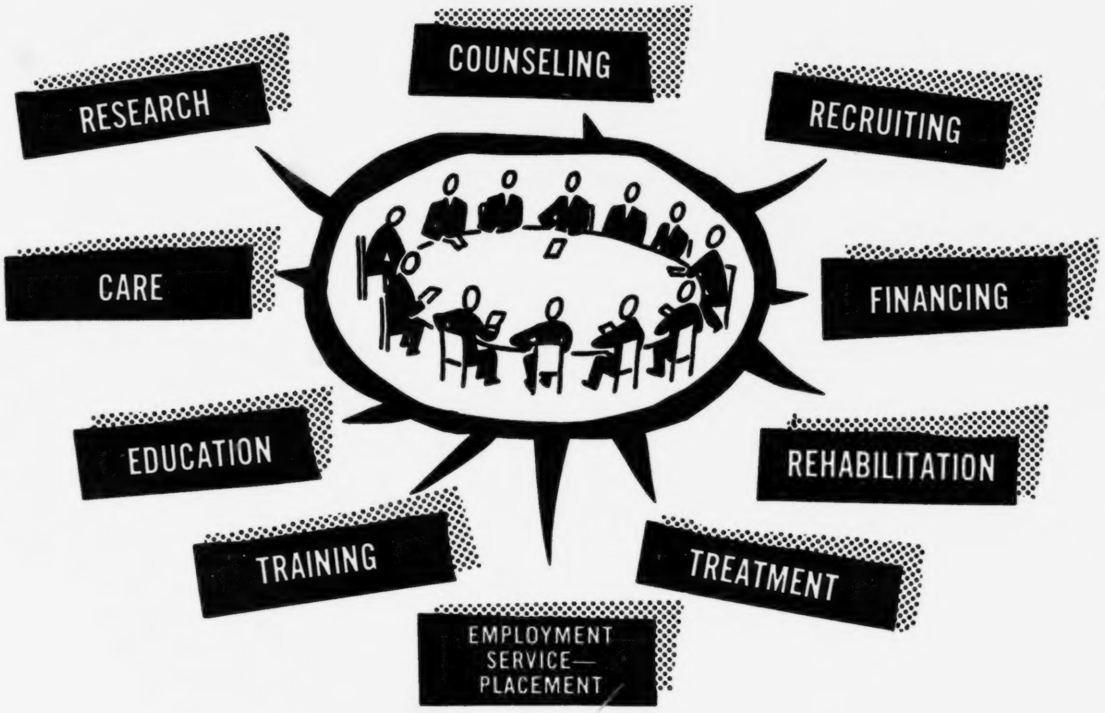
124. The public awareness program should be the continuing responsibility of the Division of Mental Retardation, with funding adequate to accomplish the above aims.

125. Wherever possible, in public education, the word "mental" should be dropped and the word "retarded" should stand alone, thus avoiding the common confusion of retardation with other mental disorders which are unrelated and separate entities.

X

COORDINATION

IMPROVED COORDINATION OF SERVICES
AT FEDERAL, STATE AND LOCAL LEVELS


COUNSELING
RESEARCH
RECRUITING
CARE
FINANCING
EDUCATION
REHABILITATION
TRAINING
TREATMENT
EMPLOYMENT SERVICE—PLACEMENT

COORDINATION

Introduction

The previous chapters have indicated the diversity, extent and gaps in services and facilities presently available to meet the needs of the mentally retarded in Florida. It is hoped that the new services and facilities recommended elsewhere in this report will soon be forthcoming. The recommendations have been designed to eliminate the gaps in present programs for the retarded. The fact that we have such a wide array of services, and the fact that new services and facilities are constantly being added to the state program for the mentally retarded, make it imperative for the State of Florida to administer and coordinate these services in such a way as to insure efficient, economical functioning.

The responsibilities for providing the wide array of services required for Florida's program in mental retardation are presently shared by several state agencies and local semi-autonomous agencies. Inadequacies in planning, coordination and financing have caused the program and its available services to lag far behind the needs of Florida's population. An adequately planned, coordinated and financed program for the mentally retarded citizens of Florida is urgently needed at all levels of government in order to insure that the needs of these citizens are met.

There have been previous efforts to achieve coordination prior to the current comprehensive mental retardation and mental health planning activities. Those responsible are commended for their previous and current efforts to achieve coordination of services in these areas. The following are some of the steps previously taken toward state-wide planning and coordination of such services:

1. Since 1959, each Legislature has appointed a committee to study and make recommendations concerning mental retardation and mental health.

2. In 1961, the Legislature authorized and financed a study of the

State's mental health needs and resources which was conducted by the American Psychiatric Association.

3. In 1961, the directors of five state agencies offering services related to mental retardation and mental health voluntarily formed an Interagency Committee designed to meet the needs for program coordination and to provide for joint planning. Subsequently, the committee was expanded and ultimately included the directors of seven state agencies. But this committee meets informally, coordination efforts are informal and the exchange of ideas seems to be the most beneficial result of committee conferences.

The efforts of the Interagency Committee, and all previous coordination efforts at all levels, are to be commended, but the Planning Committee must nevertheless conclude that much is currently lacking in coordination of available services for the mentally retarded. The recommendations submitted will assure maximum utilization of Florida's current and future resources and services in providing for the most effective program for the mentally retarded citizens of Florida.

RECOMMENDATIONS

126. We recommend that State Interagency Committee on Mental Retardation for the joint planning and coordination of public services for the mentally retarded be legally established, as a continuing body, in the State of Florida.

The State Interagency Committee on Mental Retardation should be appointed by the Governor who should act on the major recommendations of the Committee. When establishing the Interagency Committee, the Legislature should specify the general class of membership. Representatives from all state agencies having responsibility for services to the retarded should be included (Division of Mental Retardation, Division of Mental Health, Division of Vocational Rehabilitation, Welfare, Employment Service, Office of the Attorney General, Child Training Schools, State Department of Education, Board of Regents and the State Board of Health) as well as representatives of private and voluntary organizations, local governmental units and the "consumers" (parents of retarded children) of services to the retarded. The Committee should be restricted initially to a membership of 15 people.

The functions of the Committee should be to determine the total state-wide needs of the mentally retarded so that state and local responsibilities may be delineated, to stimulate programs of research and training of professional personnel, and to do joint planning and coordination of state services. The Committee should be responsible for stimulating the development of new programs and should annually revise and develop a coordinated plan for the provision of services to the retarded. This type of action is already being used to good advantage in several states.

Funds should be appropriated to the Committee for the employment of an executive secretary, supporting clerical staff and for making grants designed to stimulate research and the development of new services not now provided or assigned to any existing agency. The committee itself, would not provide new services or conduct research, but would be given funds to purchase or stimulate the development of such services and to support research and demonstration projects. The Committee, therefore, should be empowered to enter into contracts for the purchase of services.

The committee should assess current services, and where overlap in services exist, should be empowered to determine the agency that should be primarily responsible for the provision of a particular service.

The designation of a State Interagency Committee on Mental Retardation whose authority stems from the Governor is preferable to the designation of a single state agency as the coordinating agent. The rationale for this position is straight-forward. As expressed by L. W. Stringham, in *Professional and Governmental Roles in Mental Retardation,*

> Those with experience in the administration of public programs know that one agency does not take kindly to direction from another agency on the same level of responsibility. . . . . With all due respect to the good intentions of a single agency, it cannot exert any great policy direction or play a decisive role in obtaining policy changes or in securing the development of new programs in other agencies. (pp. 13-14)

127. Within each state agency which provides major services for the retarded, there should be at least one special consultant with sufficient agency-wide authority and responsibility for the development and coordination of services to the retarded.

The primary mission of many of the state agencies recommended above for inclusion in the State Interagency Committee on Mental Retardation involves the provision of services for areas other than mental retardation. It would not be realistic to expect the director of a state agency whose primary mission lies in other areas to be a specialist in mental retardation. Yet, such agencies provide major services for the retarded; hence, there should be at least one individual within such agency who would be responsible for the development and coordination of services to the mentally retarded in that agency. The individual assigned such responsibility should be delegated sufficient agency-wide authority to assume such a responsibility.

128. A Legislative Committee on Mental Retardation should be established at each biennial session of the Legislature.

This recommendation simply commends the precedent already established by the Florida Legislature. The annual existence of the Legislative Committee on Mental Retardation will continue to provide the vehicle through which many of the recommendations made in this report will be considered for legislative implementation.

129. Funds should be appropriated for use by the State Interagency Committee on Mental Retardation to finance pilot projects regarding the most efficient means of providing coordinated services for the mentally retarded at the community level.

There are many unanswered questions related to the most efficient manner in which a comprehensive and coordinated continuum of services to the mentally retarded may be provided. Since, such comprehensive services for the retarded have been practically non-existent, there are many guidelines for their development yet to be determined. Undoubtedly, the most efficient local pattern of comprehensive services for the retarded will vary from community to community. Three general types of communities might be utilized in the pilot projects: metropolitan, urban and rural. Various approaches to the most efficient means of providing a continuum of care should be utilized; the approach to be determined by the State Interagency Committee on Mental Retardation. In these pilot projects, all phases of a comprehensive program for the retarded should be activated. Current services and facilities would be utilized as appropriate. Needs for new services would be purchased and assigned to existing agencies if at all possible by the State Interagency Committee on Mental Retardation.*

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* Explanatory Note: Certain services, not assigned to existing agencies at the time of the completion of this report, have been assigned to the newly established Division of Mental Retardation by the 1965 Florida Legislature. The assignment of new services for the retarded to existing agencies, when possible, is in keeping with the recommendations of this report.

It should be noted that the establishment of the Division of Mental Retardation occured subsequent to the deliberations of the Planning Committee; therefore, the Planning Committee was unable to react specifically relative to its detailed view of the role of the new Division in the overall State Plan. The Planning Committee was aware of the provisions of the bill to create the new Division and registered no opposition to the plans for its creation. Hence, it can be conjectured that the Planning Committee did not visualize the proposed Interagency Committee on Mental Retardation as a replacement for the new Division; rather, the State Interagency Committee on Mental Retardation would complement the Division. The relationship between the newly established Division and the State Interagency Committee on Mental Retardation, proposed herein, is in need of further elaboration and clarification by future planning and implementation groups.

130. The State Interagency Committee on Mental Retardation should maintain close liaison with the community organization coordinating programs for the retarded.

The establishment of local action groups organized for the purpose of providing a continuum of services to the retarded should be encouraged. The composition of the local action groups would be, in most instances, similar to the composition of the State Interagency Committee on Mental Retardation. The local action groups would strive to ensure that local plans and programs were coordinated with state plans and programs.

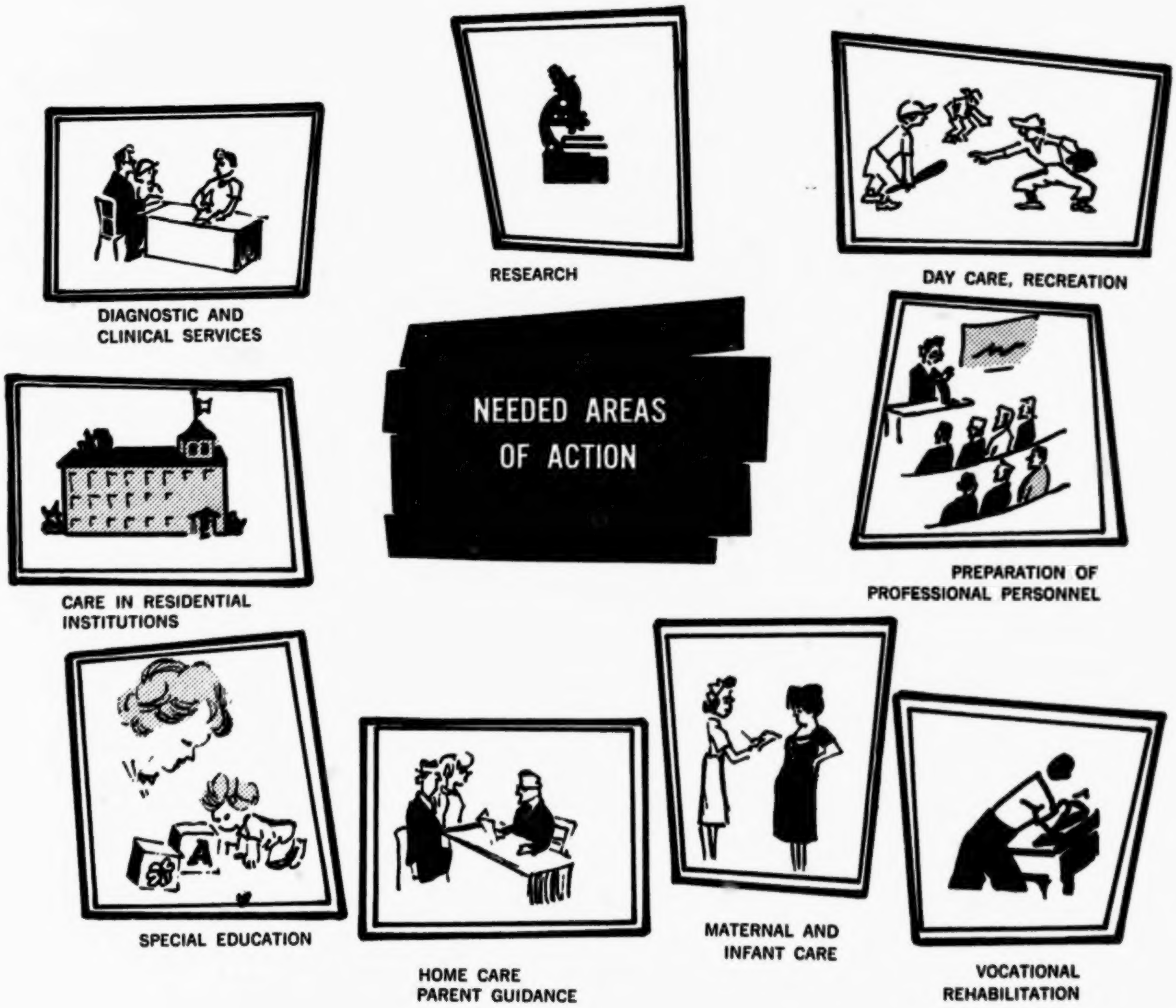
131. The programs for the mentally retarded and the mentally ill should remain under separate state administrative authority.

Although the problems of mental illness and mental retardation are related in that both conditions may occur in the same person and frequently require the same kind of professional skills in diagnosis and care, there are basic differences between the two conditions which require different concepts, procedures and objectives in program planning. However, close liaison between the groups planning programs for the mentally ill and the retarded should be maintained to ensure maximum utilization of community resources.

The broad scope of the problem of mental retardation suggests that no one agency, unless it includes all health, education, welfare and employment activities, is broad enough in scope to provide all of the general and specialized services that are needed by the retarded.

XI

COMMITMENT TO ACTION


NEEDED AREAS OF ACTION
RESEARCH
DAY CARE, RECREATION
DIAGNOSTIC AND CLINICAL SERVICES
CARE IN RESIDENTIAL INSTITUTIONS
PREPARATION OF PROFESSIONAL PERSONNEL
SPECIAL EDUCATION
HOME CARE PARENT GUIDANCE
MATERNAL AND INFANT CARE
VOCATIONAL REHABILITATION

COMMITMENT TO ACTION

Planning without action is futile; action without planning is fatal. The State of Florida and the other 49 states and four of the five eligible jurisdictions have been actively engaged in comprehensive planning. This has been done so that the mentally retarded might become as productive to themselves and to society as it is within their capacities to become. This report records the observations and recommendations of a dedicated group of citizens of Florida who have given of their time and skills to this concerted effort.

However, this report and these many recommendations will only change the lives of the mentally retarded and those who might be mentally retarded, as they are activated and altered to adapt to changing conditions. Research findings will prevent an appreciable amount of mental retardation. These findings will lead to new and better ways of providing for the medical, educational, social and vocational needs of the mentally retarded. Legislators and those who will be activating these recommendations must be continually aware of these changing conditions.

The only constant factor in the present era seems to be change — constant, never-ending. Margaret Mead quite properly states that, "the most vivid truth of the age is that no one will live all of his life in the world in which he was born." Richard K. Paynter, Jr., Chairman of the Board of the New York Life Insurance Company, says, "The flexible mind is able to discard comfortable habits and calcified attitudes that no longer measure up to the truth of the times."

Awareness is essential in relating to change. We must have a premonition or a feeling for what is to be. We must not only handle the problems and needs of the mentally retarded today but prepare to meet the needs of tomorrow. The British statesman, Edmund Burke, once said, "The public interest requires doing today the things that men of intelligence and good will would wish, five or ten years hence, had been done."

Planning does not mean doing more of what we are and have been doing. Planning demands creative, daring, forward thinking, breaking with traditions, relating to changes which affect vested interests but are for the best interests of the mentally retarded. We are not doing this kind of planning as well as should be done. There is a frightening urgency to such planning. The way our societal pattern is moving and changing is challenging and exciting but frightening. There is no place for complacency. Planning must be a continual, on-going process. We must use all the facts, trends and experiences of others throughout the world in finding new and better ways to provide for the mentally retarded.

Population projections are staggering. Yet we are not building programs and training staff to provide for the mentally retarded of the future. The population of the United States will double in 40 years but in the State of Florida it will double in 20 years. Will we be ready with medical, education, vocational and care and treatment programs to meet the needs of the mentally retarded?

The need to expand educational opportunities for the mentally retarded is urgent and staggering. 3 out of every 4 retarded children today receive no special instruction. They are left to shift for themselves in classrooms where they do not have the ability to compete and to know success. They are the vanguards of early dropouts.

Though state and federal legislation continues to make provisions for the expansion of teacher training programs, the fact remains that, without an effective prevention program, it will take several years before the number of qualified teachers will be sufficient to meet the needs of the increasing number of school-age retarded children. Perhaps patterns other than those currently used for providing qualified staff should be considered as essential for meeting the future educational and training needs of the retarded.

The phenomenal shift of population from rural to urban areas must be given careful consideration in providing programs for the mentally retarded. Services cannot be provided in respect to counties where people were when we traveled by horse and buggy. Services and programs for the mentally retarded must be provided where people are and even more importantly where they will be tomorrow. Programming must relate to transportation facilities, available personnel and quality programming rather that the civic pride of towns and counties. Our planning for the future must adequately consider how and where we can best provide the needed research and programs for the mentally retarded. We must relate to populations and to crossing township, county and even State lines to provide better programs.

Let us be sure that comprehensive planning for the mentally retarded includes considerations and needs for the life span of this segment of society. The best special education program in the country will not provide a new way of life for the mentally retarded unless work opportunities are made available at varying levels of productivity. The best diagnostic and evaluation procedures will be lost if there are not professional staff working together with families to see that the findings are implemented. The programs need to be well balanced. We must find a way to staff the programs for today and tomorrow.

Agencies must take more efficient utilization of the limited professionally training personnel who will be available for research, medical, educational, social and vocational programs for the mentally retarded. More utilization of assistants, aides and volunteers must work under the supervision and direction of those with greater training and experience. We must create new training programs for individuals to do the kinds of jobs which have not been thought of at this time. We must consider radical departures from the present ways of training and using manpower. The jobs we are to do may bear little resemblance to the jobs we are doing. Are our educational programs training people to be as pliable and fluid with ability to change with the times, as will be essential? Do we realize that the supreme challenge to state planning is to recognize that today's training in the several professional fields is going to be outdated a few years from now, and to plan accordingly?

Careful and continual planning simply tends to speed up the acceptance of the inevitable. Irving Stone tells the life story of Michelangelo in *The Agony and The Ecstasy.* Many times Michelangelo was without funds. At one time a financially successful artist explained that "to be successful in Rome you must give people exactly what they want." Michelangelo answered, "What would happen to a sculptor who said to himself, 'What is, must be changed'?" The other artist answered, "Changed? For the sake of change?" Michelangelo replied, "No, because he felt that each new piece he carved had to break through the existing conventions, achieve something fresh and different." This was in 1505.

In 1965, 460 years later, present and future planning must break through other conventions, achieve things which better fit the needs of our citizenry. The Florida Plan for Comprehensive Action to Combat Mental Retardation provides something "fresh and different" for the mentally retarded. It proposes new and better ways to prevent mental retardation. The Plan proposes extension of present programs and new approaches to others which relate to the mentally retarded. Eternal vigilance and further change are essential in planning for prevention and for the health, education and welfare of the mentally retarded.

In a State which is growing as rapidly as Florida, it is necessary to provide for continuous study of the needs and periodic revision of the Plan. Some of the subjects that should receive attention in the years immediately ahead are:

1. The incidence and prevalence of mental retardation in Florida. As already indicated, there is need for studies in the identification of the mentally retarded that will produce more accurate and useful data for planning and for programming of services.

2. Present and to-be-established services for the mentally retarded require continuing review and evaluation. This is necessary both to prevent the perpetuation of inadequate services and to make more widely available the knowledge which grows out of successful experience.

3. Continual community self-study and organization of coordinated local services on a continuum basis. An increasing number of Florida communities and counties are engaged in self-examination of their programs for the mentally retarded. It would be helpful if they could share their methods and in addition receive guidance from the State Division of Mental Retardation.

4. Public attitude studies. The report has noted the importance of a favorable and understanding climate of public opinion. In order to bring public attitudes in closer conformity with present-day information, it is important to know what those attitudes are. There is a role for opinion research, specific enough to differentiate among the many segments of the general public — parents, neighbors, professional people, civic leaders, businessmen, farmers, working people and others.

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APPENDICES

STATE ADVISORY COMMITTEE ON MENTAL RETARDATION PLANNING
DIRECTORY — TASK FORCE ORGANIZATION
APPENDIX A

PREVENTION, CLINICAL DIAGNOSIS, EVALUATION AND TREATMENT

Chairman: D. L. Crane, M. D.

Members: E. L. Flemming, Ed. D., F. L. Fort, M. D., I. E. Gaston, R. N., E. H. Gates, M. D., M. Greer, M. D., F. Loeffler, Ph. D., Frances McGrath, J. D. Milton, M. D., B. M. Moulton, R. N., E. L. Nixon, Carol Shear, M. D., G. F. Smith, M. D.

COMMUNITY AND RESIDENTIAL SERVICES

Chairman: Pearl Nelson

Members: Jim Cox, Frances Davis, Sigfried Dayan, Robert Eaton, Art Forehand, Barbara Green, Lois Hill, J. R. E. Lee, Jr., Henry Lubin, Frances McGrath, John Monkman, Ph. D., Betty Mudgett, Bert Muller, Jean Mundy, Richard Snyder, William Tait, Ed. D., G. Franklyn Ward, William Young, D. E.

SPECIAL EDUCATION, TRAINING, REHABILITATION AND EMPLOYMENT

Chairman: Landis Stetler

Members: Dolores Benedict, Jo Anne Cox, Dale R. Fjeran, Charles Gesslein, Edward Kerr, Mary Lou McEver, William McEntee, Alan Mundy, Dodd Pace, Henry Richards, Robert Saunders, Richard Synder, Ellen Thiel, Julia Wickersham, Mabel Wunderlich

RESEARCH

Chairman: C. H. Carter, M. D.

Members: Robert M. Allen, Ph. D., W. B. Barrow, M. D., Mrs. Pauline Barton, R. N., Ed. D., Mrs. Dolores Benedict, Lydia Bowen, R. N., Evan L. Copeland, M. D., C. H. Dutcher, R. C. Feathers, Richard Fox, Inez Gaston, R. N., Melvin Greer, M. D., Albert Hardy, M. D., G. S. Hasterock, Ph. D., Andrew E. Lorincz, M. D., Joan O'Brien, R. N., Ed. D., Leslie Malpass, Ph. D., William L. Nyhan M. D. Calvin Pinkard, Ph. D., Sylvia Rapp, Thomas Routh, George Smith, M. D., Florence Walters, G. Franklyn Ward, Ray Wunderlich, M. D. William C. Young, D. E.

LAW AND PUBLIC AWARENESS

Chairman: Gerald Mager

Members: Bjarne B. Andersen, Judge McKenny J. Davis, William Mapoles, Sidney Martin, Judge John H. McCormick, Bert Muller, Dolores Norley, R. C. Philips, John Presley, Ph. D., Warren W. Quillian, M. D., Landis Stetler.

COORDINATION

Chairman: James G. Foshee, Ph. D.

Members: Task Force Chairmen

CONSULTANT

Darrel J. Mase, Ph. D., Dean
College of Health Related Professions
The J. Hillis Miller Health Center
University of Florida
Gainesville

APPENDIX B

MENTAL HEALTH AND MENTAL RETARDATION LEGISLATION PASSED BY THE 1965 SESSION OF THE FLORIDA LEGISLATURE.

House Bill 114 — Chapter 65-13

Amends Section 965.01(3), F. S., to provide a broader scope of authority to the Division of Mental Health and extends its responsibilities to include planning, development and coordination of a complete and comprehensive state-wide program of mental health including community services, the state mental institutions, child services, research and training. The Division of Mental Health is designated the mental health authority of the State of Florida.

Section 965.01(3), F. S., also set qualifications for the director of the division as a qualified licensed practicing physician of medicine. The director shall be responsible for the administration and operations of all state-operated mental health community inpatient and outpatient facilities. He shall also be responsible for requisite supervision of all state supported faciltiies.

This section also provides for the establishment of a nine-man advisory board to the director of the division. Three of the members shall be licensed physicians, one being a psychiatrist. One member of the board shall be a member of the Florida Association for Mental Health. The remaining five members will be chosen from the citizens of the state.

House Bill 115 — Chapter 65-14

Amends Section 965.01(4), and 965.04(3), F. S., by redesignating the Division of Sunland Training Centers as the Division of Mental Retardation and prescribes the responsibilities and duties of the Division for the administration and operation of all state operated facilities established for the diagnosis, care and training of the mentally retarded and shall provide requisite supervision relating to mental retardation of all state-supported facilities for the retarded.

The director of the division shall not have any administrative or supervisory responsibility over any phase of the state system of higher education, the public schools, vocational rehabilitation program or other educational institutions as defined in Section 228.041(1), F. S.

This act also provides for advisory board to the director. This board shall consist of seven members; one shall be a practicing physician limited to pediatrics; one shall be a member of the Florida Association for Mental Retardation and one shall be a member of the Council for Exceptional Children.

House Bill 116 — Chapter 65-5

Amends Section 394.22(16) (a) by deleting the thirty-day observation period required for the issuance of a certificate of restoration to sanity. Certificate of sanity may be issued by the superintendent if a majority of the medical staff are of the opinion said person has recovered his reason.

House Bill 118 — Chapter 65-6

Amends Section 391.01, F. S., relating to crippled children; redefining the term "cripple children" by deleting the "normal mentality" requirement from the definition.

House Bill 119 — Chapter 65-21

Amends Section 394.01, F. S. by naming the hospital in Gadsden County as the Florida State Hospital.

States that patients shall be committed only to the director of the division of mental health who shall assign such patient to such institutions as he may deem proper.

House Bill 120 — Chapter 65-22

Amends Section 394.012, F. S., by naming each hospital as a separate hospital under the Division of Mental Health rather than as branch hospitals of the Florida State Hospital.

House Bill 122 — Chapter 65-23

Amends Section 394, F. S., authorizes the medical staff of a state hospital to relesase a patient for a trial visit to his home or another place approved by the hospital after a determination that such visit would be beneficial to the patient and upon such conditions as the hospitals may impose. Authorizes discharge of an absent patient at the end of the certification period.

Senate Bill 224 — Chapter 65-43

Amends Section 394.25, F. S., to permit the admission to the state hospitals of persons voluntarily requesting admission in accordance with Section 394.20, F. S.

Senate Bill 225 — Chapter 65-44

Adds subsection 394.20(5), F. S., making reasonable charges for the care and treatment of patients voluntarily admitted to state hospitals lawful charges against the person and estate or property, real, tangible or intangible; of the person in the same manner as provided in Section 394.22, F. S. for committed incompetents.

House Bill 165 — Chapter 65-585

Directs the Board of Commissioners of State Institutions to establish the Sunland Adult Center at Arcadia to be located at Dorr Field in De Soto County for custody and care of retarded adults. The center shall not be established until all mental patients now housed at this site are moved.

House Bill 179 — Chapter 65-511

Amends Section 402.07, F. S., relating to repayment of mental health scholarships, by providing a list of state and public institutions and agencies in which employment may be used as repayment of a scholarship loan.

House Bill 395 — Chapter 65-136

Adds Section 393.022, F. S., to provide an alternate method of admission to Sunland Training Centers, by application in writing to the county judge where the person sought to be admitted resides. The county judge, being satisfied that the applicant is 21 years of age or that the application is by the parent or legal guardian of the person to be admitted, shall forward the application to the Director of the Division of Mental Retardation who may admit such person if he feels that the person is mentally retarded. The superintendent of the center, with the approval of the Director of the division shall discharge any voluntary patient who, in his opinion, can no longer benefit from his stay in the institution.

House Bill 602 — Chapter 65-386

Amends Section 490.011, F. S., defining psychologist to omit the requirement that the services rendered be "for remuneration."

Amends Section 490.041, F. S., to provide that each applicant for a certificate from the Board of Examiners of Psychology must show that he conforms to the ethical standards of the profession as adopted by the Board; and increases the experience requirements from one to two years, specifying more clearly the phrase "experience in the field of psychology."

Amends Section 490.05, F. S., to provide that the Board may waive the examination for applicants recognized as diplomats by the American Board of Examiners in professional psychology and for applicants certified in other states having equal standards.

Provides for privileged communications in certain instances.

House Bill 610 — Chapter 65-529

The boards of county commissioners of this state are authorized to contract for services and facilities for a period not to exceed two (2) years with public and private hospitals; clinics; laboratories; other state agencies, departments or divisions; the state colleges and universities; counties, municipalities, towns, townships, or any other governmental unit which provides needed facilities for the mentally ill or retarded. The county commissioners may make periodic inspections to assure that the contracted services provided meet the standards of the division of mental health and division of mental retardation.

Committee Substitute for House Bill 902 — Chapter 65-404

Adds Section 90.242 providing a privilege of non-disclosure for communications between patient and psychiatrist.

There shall be no privilege if the patient is under psychiatric examination ordered by the court on issues involving the patient's mental condition; in a criminal or civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or after the patient's death, when the condition is introduced by any party claiming or defending through or as a beneficiary of the patient.

Senate Bill 714 — Chapter 65-145

Adds Section 394.013, F. S., authorizing and *directing* the Board of Commissioners of State Institutions to establish a branch of the state hospital to be known as the west coast branch in Hernando County.

House Bill 1978 — Chapter 65-519

Adds Section 383.15, F. S., to require the State Board of Health to promote and prescribe rules for the testing of all infants for phenylketonuria and other metabolic disorders when such tests become available and practical in the judgment of the state health officer; and to keep a record of said tests. However, if one or both of the parents object, such tests shall not be given.

APPENDIX C

DISTINCTION BETWEEN MENTAL RETARDATION AND MENTAL ILLNESS

The following is an official statement by the U. S. Department of Health, Education and Welfare on the distinction between mental retardation and mental illness. This statement was widely used at the time the mental retardation legislation was under consideration, and more recently has been included in **New Approaches to Mental Retardation and Mental Illness.**

> "It should be emphasized that mental retardation and mental illness are in most instances separate problems. There has been much misunderstanding on this point among the general public. Mental retardation is usually a condition resulting from developmental abnormalities that start prenatally and manifest themselves during the newborn or early childhood period. Mental illness, on the other hand, includes problems of personality and behavioral disorders especially involving the emotions; it usually manifests itself in young and older adults after a period of relatively normal development.
>
> "There is always a deficit in intellectual function in mental retardation; mental illness may or may not involve such a defect. If there is any involvement of intellectual function, it is usually not of the nature and degree found in mental retardation.
>
> "The two problems are related in that they may occur in the same patient and frequently involve some of the same kinds of professional skills to diagnose or assist the patient. On the other hand, each problem does occur independently of the other and adequate professional skill to deal with one problem does not assure competency to deal with the other. The ability to distinguish clearly between these problems in a given patient and to deal with each appropriately is often the crux of good care." (U. S. Department of Health, Education and Welfare, Office of the Secretary, November, 1963).

APPENDIX D

DEVELOPMENTAL CHARACTERISTICS, POTENTIAL FOR EDUCATION AND TRAINING, AND SOCIAL AND VOCATIONAL ADEQUACY ACCORDING TO THE FOUR LEVELS OF MENTAL RETARDATION

(Classification Developed by the American Association on Mental Deficiency)

LEVEL	PRE-SCHOOL AGE 0-5 MATURATION & DEVELOPMENT	SCHOOL AGE 6-21 TRAINING & EDUCATION	ADULT 21 & OVER SOCIAL & VOCATIONAL ADEQUACY
PROFOUND	Gross retardation; minimal capacity for functioning in sensori-motor areas; needs nursing care.	Obvious delays in all areas of development; shows basic emotional responses; may respond to skillful training in use of legs, hands and jaws; needs close supervision.	May walk, need nursing care, have primitive speech; usually benefits from regular physical activity; incapable of self maintenance.
SEVERE	Marked delay in motor development; little or no communication skill; may respond to training in elementary self-help, e.g., self-feeding.	Usually walks barring specific disability; has some understanding of speech and some response; can profit from systematic habit training.	Can conform to daily routines and repetitive activities; needs continuing direction and supervision in protective environment.
MODERATE	Noticeable delays in motor development, especially in speech; responds to training in various self-help activities.	Can learn simple communication, elementary health and safety habits, and simple manual skills; does not progress in functional reading or arithmetic.	Can perform simple tasks under sheltered conditions; participates in simple recreation; travels alone in familiar places; usually incapable of self maintenance.
MILD	Often not noticed as retarded by casual observer, but is slower to walk, feed self and talk than most children.	Can acquire practical skills and useful reading and arithmetic to a 3rd to 6th grade level with special education. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to self maintenance; may need occasional guidance and support when under unusual social or economic stress.

Source: The President's Panel on Mental Retardation, Mental Retardation, A National Plan for a National Problem: Chart Book. U.S. Department of Health, Education, and Welfare, Washington, D. C., 1963, p. 15.

APPENDIX E

ESTIMATED POPULATION FOR FLORIDA COUNTIES*

	1964	1965	1970	1975
Alachua	85,000	87,100	99,800	108,300
Baker	7,800	8,000	8,800	10,000
Bay	69,000	70,400	74,400	84,700
Bradford	13,000	13,200	14,300	15,300
Brevard	157,000	167,800	250,000	281,800
Broward	410,000	436,000	700,000	744,000
Calhoun	7,800	7,900	8,300	8,900
Charlotte	19,500	24,900	45,000	50,500
Citrus	11,000	11,500	14,100	17,800
Clay	19,500	19,600	27,000	31,000
Collier	23,000	24,800	39,000	56,500
Columbia	22,000	22,600	25,300	28,100
Dade	1,143,000	1,167,100	1,400,000	1,543,300
De Soto	13,100	13,600	16,300	19,000
Dixie	4,800	4,800	5,200	5,700
Duval	510,000	522,000	662,000	714,000
Escambia	195,000	199,300	237,300	268,700
Flagler	5,300	5,400	6,100	7,200
Franklin	7,300	7,500	8,100	8,900
Gadsden	46,000	47,400	54,400	60,000
Gilchrist	2,900	2,900	3,000	3,100
Glades	3,300	3,400	3,900	4,400
Gulf	9,800	10,000	11,400	13,400
Hamilton	7,800	7,800	7,900	8,100
Hardee	13,500	13,800	15,500	16,500
Hendry	10,500	11,000	12,600	14,400
Hernando	12,500	12,900	16,700	21,300
Highlands	24,400	25,400	31,200	37,300
Hillsborough	437,000	447,600	504,000	584,000
Holmes	11,100	11,200	11,700	12,100
Indian River	32,900	34,700	48,400	62,800
Jackson	37,200	37,600	40,600	43,600
Jefferson	10,300	10,600	11,900	13,100
Lafayette	3,100	3,200	3,600	4,000
Lake	63,000	64,700	75,900	85,000
Lee	69,200	70,700	96,000	126,000
Leon	83,000	85,900	96,300	110,000
Levy	11,300	11,800	13,300	14,500

	1964	1965	1970	1975
Liberty	3,000	3,000	3,100	3,200
Madison	14,900	15,100	15,600	16,100
Manatee	80,000	82,600	109,000	140,500
Marion	59,900	62,500	70,100	77,600
Martin	22,300	24,000	38,000	49,000
Monroe	55,000	57,600	64,300	72,600
Nassau	19,500	20,100	22,000	24,400
Okaloosa	65,900	67,700	84,100	98,000
Okeechobee	8,200	8,500	11,700	14,100
Orange	307,000	318,200	450,000	535,300
Osceola	21,000	21,800	28,300	36,500
Palm Beach	284,500	299,500	440,000	478,000
Pasco	40,200	49,200	56,200	69,800
Pinellas	426,000	441,000	530,000	626,000
Polk	215,000	220,800	248,300	280,000
Putnam	34,000	34,400	38,000	44,000
St. Johns	32,900	33,700	37,500	43,000
St. Lucie	47,000	48,800	71,000	96,000
Santa Rosa	33,900	35,100	41,000	48,400
Sarasota	93,000	97,600	143,000	184,000
Seminole	67,000	71,200	100,000	131,000
Sumter	13,400	13,800	15,000	16,300
Suwannee	17,100	17,800	19,500	20,900
Taylor	14,100	14,400	15,400	15,900
Union	6,400	6,500	7,000	7,200
Volusia	143,000	148,700	200,000	233,800
Wakulla	5,300	5,300	5,400	5,500
Walton	16,100	16,200	16,700	16,900
Washington	11,900	12,100	13,100	13,600
TOTALS	5,769,400	5,973,300	7,592,600	8,634,900

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* Kiplinger and other sources

The 1964 population has been estimated at 5,705,000 by the Bureau of Research, Florida Development Commission. This total, rather than the Kiplinger estimate Table A, page 25 of the Plan is used to determine the estimated number of mentally retarded in Florida in 1964.

APPENDIX F

INTERAGENCY COMMITTEE ON MENTAL RETARDATION PLANNING

Counties listed below have completed their data collection and have submitted their recommendations or a plan of comprehensive services for the mentally retarded in their community.

Bay County
Calhoun County
Dade County
Duval County
Escambia County
Gadsden County
Highlands County
Hillsborough County
Indian River County
Jackson County
Lee County
Levy County
Marion County
Palm Beach County
Pinellas County
Putnam County

The remainder of the counties are still in the process of completing their survey of services and facilities. It is anticipated that each of the Community Planning Councils will have submitted their plans by November 1, 1965.

APPENDIX G

STATE OF FLORIDA
A CHRONOLOGY OF STATE PLANNING FOR COMPREHENSIVE ACTION TO COMBAT MENTAL RETARDATION 1964-1965

October 1961 — President Kennedy appointed a Panel on Mental Retardation to prepare a blueprint for a national campaign against retardation.

October 1962 — The Panel's report made to President Kennedy.

February 1963 — President Kennedy signed into law PL 88-156, *Maternal and Child Health and Mental Retardation Planning Amendments of 1963* and PL 88-164, *Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.*

The Mental Retardation Legislation of 1963 provides in large measure the means at the Federal level for giving guidance and financial support aimed at solving the problems of mental retardation. Through these two Public Laws, Congress authorized funds for the *essentials of a broad program* — planning construction of facilities, research, services and training of personnel.

PL 88-156 authorized $2.2 million to be made available to the States for initiating action for developing comprehensive plans that will provide a means of coordination for the many State and local services available to the mentally retarded.

December 1963 — Action by the Board of Commissioners of State Institutions Designation of the Division of Mental Retardation

(a) As the State agency to administer the grant and carry out the purposes of PL 88-156.

(b) As the State agency for the supervision of the administration of the State plan for construction of mental retardation facilities as required by PL 88-164. The Act makes no provisions for Federal financial support to States for construction planning.

March 1964 — Governor Farris Bryant appointed:

1. *The Interagency Committee on Mental Retardation Planning.* The Committee is composed of the Directors of (a) Division of Mental Retardation, (b) Board of Regents, State University System, (c) State Welfare Department, (d) Vocational Rehabilitation, (e) the Deputy Superintendent, State Department of Education, (f) the Chief of Programs and Methods, State Employment Services,

(g) the Deputy State Health Officer, State Board of Health and (h) an Assistant Attorney General. (Page v of the Plan)

2. *The State Advisory Committee on Mental Retardation Planning.* It is composed of 20 individuals representing voluntary organizations, parents of mentally retarded, and State services in the fields of education, employment, rehabilitation, welfare, health, law, public awareness and research. (Page vi of the Plan)

June 30, 1964 — Florida, upon application, was awarded $30,000 (3 to 1 matching bases) to initate planning under provisions of PL 88-156. Plan to be submitted to Washington, July 1, 1965.

July 1964 — John E. Miklos, on leave from FICUS, appointed as Planning Director. Mrs. Alton Holder, Secretary.

March 1965 — Florida received a supplemental grant of $15,000. Mr. Edward A. Kerr, formerly Information Specialist, Florida State Employment Service, was appointed Public Information Officer to provide technical assistance to communities on public education and awareness of mental retardation.

June 1965 — An amended award statement was issued by the U. S. Department of Health, Education and Welfare, Washington, extending the Mental Retardation Planning Grant to December 31, 1965, and incorporated the budgets of the initial and supplemental grants.

PLANNING PROGRESS

State Level — First meeting of the Advisory Committee held in Tallahassee, August, 1964 to discuss the dimensions of the task. Subsequent meetings held monthly. Six Task Forces were established and Task Force Chairmen selected. (Appendix A) Through its Task Forces the Advisory Committee's objectives were as follows: (a) to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, (b) to develop public awareness of the mental retardation problem and the need for combating it, (c) to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration and (d) to plan other activities leading to comprehensive State and community action to combat mental retardation. Tentative reports of the Task Forces were submitted on January 21-22, 1965 for study and recommended revisions. A second review was held by the Advisory Committee on March 25-26, 1965. On May 19, 1965, the first draft of the State Plan was submitted to the Interagency Committee for review. The Advisory Committee met the following day, May 20, in Tallahassee, to consider the Interagency Committee's recommendations.

Final approval of the State Plan was given by the Interagency Committee on Mental Retardation Planning on June 28, 1965. Mimeographed copies of the Plan were prepared for use by the Staff and related State agencies while the Plan was being printed for official distribution.

Arrangements were made for Mr. Gerald Mager, Chairman of the Interagency Committee on Mental Retardation Planning and Mr. William Mapoles, Director, Division of Mental Retardation, to present the State Plan to Governor Haydon Burns on July 6, 1965.

Local Level — In cooperation with the State Board of Health (the State agency designated to submit the State Plan for mental health), guidelines for planning and data collection forms were published and made available in each of the 67 counties to the following: County Planning Councils, County Superintendents of Public Instruction, County Health Officers and Nurses, County Coordinators of Special

Education, Local Associations for Retarded Children, Chairman, Board of County Commissioners and Presidents of the Council for Exceptional Children.

State and local associations for the mentally retarded and the mentally ill and community leaders were encouraged to organize community planning councils on mental retardation which would:

(a) Create a public awareness of the mental retardation problem and of the need for combating it.

(b) Determine local needs as to facilities and coordinated comprehensive services.

(c) Encourage planning on a continuing basis for a creative look at the future for new ways to solve old problems.

(d) Assure cooperation, communication and coordination at Federal, State and local levels to combat mental retardation.

Every county, individually or by area membership, was involved in the process of data collecting and indicated an intention to analyze their survey findings and to develop a plan of comprehensive services for the mentally retarded that live in their respective communities. As of June 15, 1965, 16 counties submitted their respective recommendations or plans of comprehensive services for the mentally retarded. (Appendix F) The remainder of the local plans are to be submitted prior to November 1, 1965.